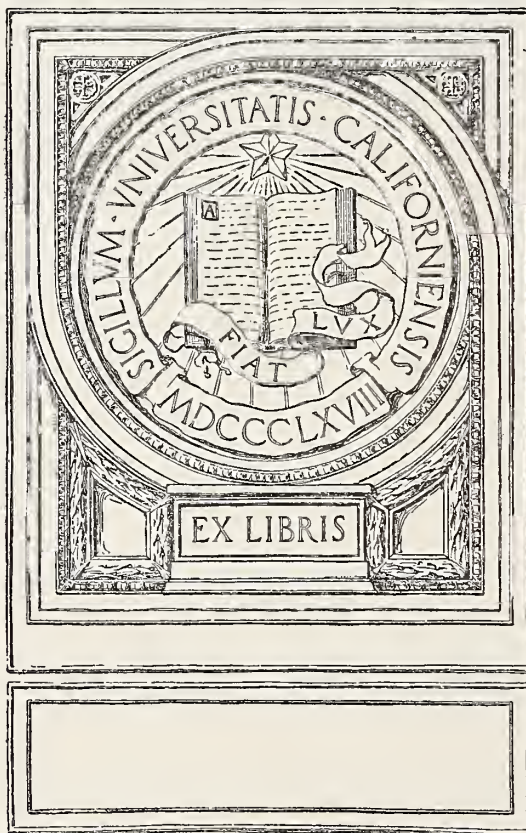
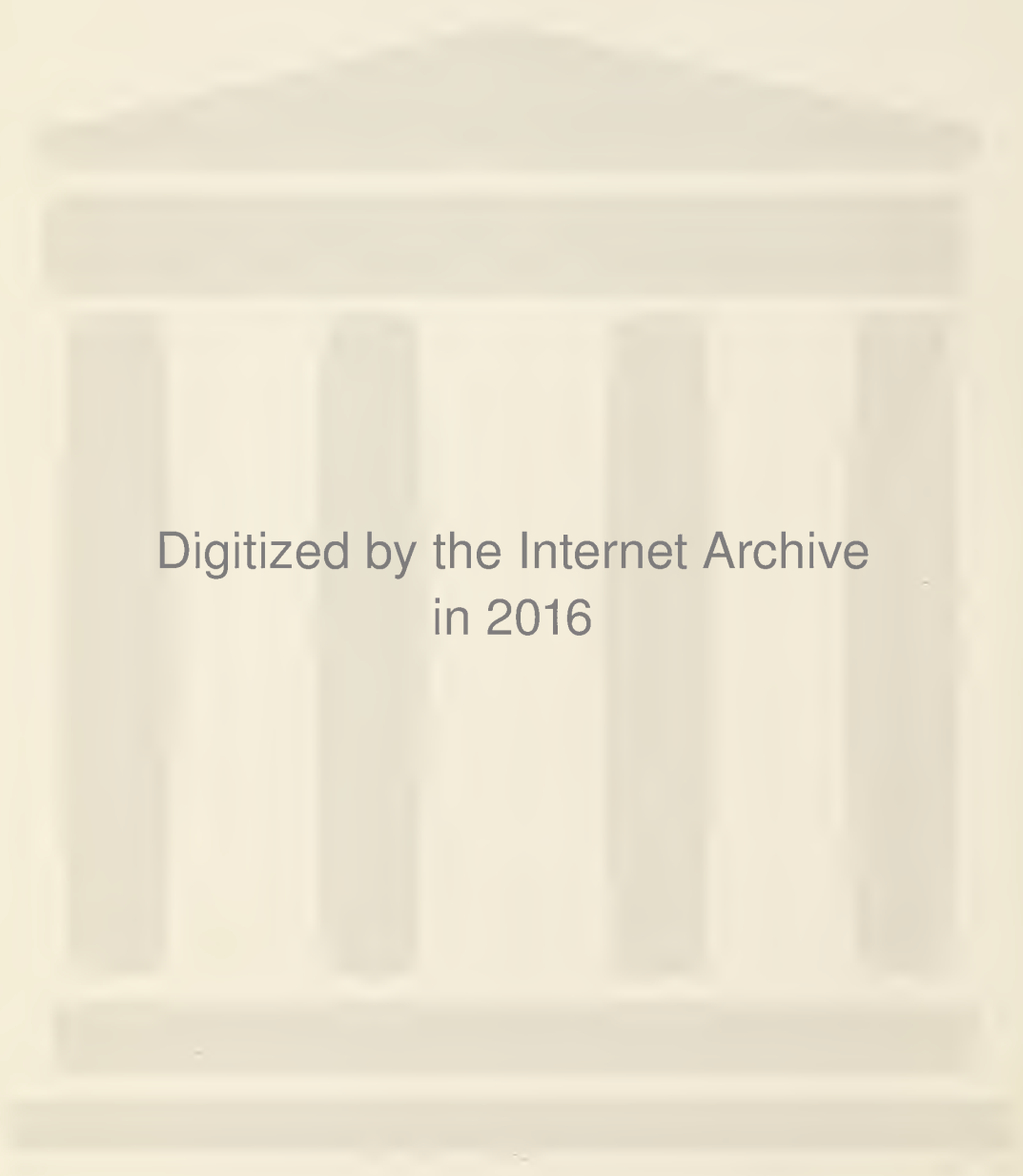


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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

Published Monthly

Edited for the Association Under the
Direction of the Council of the Association

Established 1911

EDGAR WOODY, JR., M. D., EDITOR

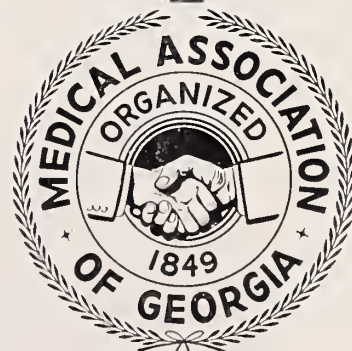
Subscription Rates: \$5 a Year, \$1 a Single Copy

Volume 44

January-December, 1955

MEDICAL ASSOCIATION OF GEORGIA

875 West Peachtree, N. E., Atlanta



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A picture of relaxation on a cold winter's night. How often do you find yourself immersed in textbooks and journals when the clock strikes 12? (Photo by Ted F. Leigh, M.D.)

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HOUSE OF DELEGATES MEETS IN MACON

UNDER HEADLINES OF "Violates Code, Doctors Say of Hospital Plans" and "Augusta Proposals Violate Medical Code" the wire service report read "Macon, Ga., Dec. 12 (AP)—The House of Delegates of the Medical Association of Georgia has approved general plans for the operation of the Eugene Talmadge Memorial Hospital at Augusta, but objected to certain provisions," was printed in the newspapers of Georgia.

A detailed report of the action of the special session of the MAG House of Delegates is carried in this issue (see The Association section) of your *Journal*. But neither a newspaper story nor a report of proceedings can give certain details which need emphasis. Editorial space is then devoted to factual comment for further clarification.

The medical profession in Georgia as represented by the MAG Council first came to grips with what they considered the problems of the Talmadge Hospital policies more than a year ago. After careful deliberation and discussion, Council appointed a committee to further study hospital operational plans. This committee reported to Council and was instructed by Council. The members of Council, cognizant of the proportion of these problems, then called a special session of the House of Delegates to deliberate and act and so state the policy of the profession in this matter. This is now history.

The delegates, duly elected representatives of each county medical society, considered the problems in orderly fashion and *disapproved* certain portions of the hospital plans. Provisions were also made for a committee to advise the authorities concerned in revising objectionable practices as contained in the plans. This too, is now history.

These decisions were made by 86 delegates representing some 40 county medical societies and 27 other members of the House. Official

attendance was 113. Forty county medical societies were not represented, but 25 of these 40 are at the present time inactive. At least 15 county societies shirked their responsibility to their colleagues by ignoring the problems of their profession and "letting George do it." As it turned out, "George did it", but those 15 to 20 societies further weakened the strength of the 80 component links that are the Medical Association of Georgia. This apathy is perhaps an even greater problem than was debated on the floor of this House session.

Council and the MAG Public Relations Committee are aware of this threat to the organization. They realize that internal disunity leads to chaos. To meet this problem, Council has recommended certain minimum standards for county medical society status. And the Public Relations Committee will soon hold conferences over the state to stimulate the activity of dormant societies.

It was gratifying to see the sense of responsibility exhibited by those delegates who did attend this meeting in Macon. The Association has risen to the occasion, and it is sincerely hoped that at the next roll call there will be no name unanswered.

POTASSIUM PROBLEMS IN PRACTICE

IT NOW BECOMES apparent that application of a working knowledge of electrolyte problems by the physician may save as many lives as the antibiotics. An understanding of sodium problems has become fairly widespread, but potassium enigmas have been solved somewhat more slowly because of the difficulty of accurate determination of intracellular electrolytes. However, enough is now known about potassium to make us realize that we can no longer afford to remain ignorant in this area.

The body water comprises about 50 to 70 per cent of its weight. Fifteen to 20 per cent of the body weight is made up by the fluid outside of the cells (extracellular or including the blood plasma) and water within the cells (intracellular fluid) is equal to 40 to 50 per cent of the body weight.

Sodium is the chief constituent of the extracellular or interstitial fluid and plasma with a concentration of about 140 mEq per liter. Potassium constitutes a relatively small but extremely important part of the extracellular fluid and plasma with a concentration of four to five mEq. per liter. On the other hand, only negligible quantities of sodium are present in the cell whereas potassium has a concentration of 157 mEq. per liter of cell water. Something within the cell seems to repel sodium and hold potassium. The mitochondria, peculiar oval structures within the cell, have something to do with holding potassium, since potassium is lost from the cell when the mitochondria are poisoned by dyes like janus green.

The average diet contains ample potassium since fruits, vegetables and meats are rich in it. Coca-Cola contains a fair amount; ginger ale is potassium free and can be given in the presence of potassium intoxication. Most of the potassium in excess of body needs is excreted by the kidney. Only a few milli-equivalents are excreted in the normal stool and only 10 mEq. are eliminated in each liter of diarrheal stool except when food passes through so fast that its potassium fails to be absorbed. Gastric juice and all digestive juices contain about the same amount, 10 mEq. per liter.

Causes of K Abnormalities

Excretion by the kidney depends upon an adequate urine volume, at least 750 cc. per day. In occasional instances of renal failure, potassium retention can occur despite a good urinary output. Retention almost always occurs with a urine volume of less than 500 cc. per day. Adrenal insufficiency can produce slight potassium retention, but not to a serious extent.

Potassium goes into the cell with glucose and comes out with lactic acid after cell activity. The kidney rapidly eliminates any K which comes out of the cell. Except with extreme deficiencies, the

body has no protection against loss of excess potassium once it is out of the cell.

Potassium loss occurs in acidosis or alkalosis of any kind. Adrenal overactivity from stress, operation, trauma, infection, ACTH, DOCA or cortisone administration causes loss of great amounts of potassium through the kidney. A low sodium intake prevents some of this loss, and a high sodium intake increases it. Prolonged chronic diarrhea, as with pancreatic insufficiency or even severe laxative abuse, can produce insufficiency. Kidney failure may cause depletion either through acidosis or, less commonly, because of a specific inability of the tubule cells to reabsorb potassium. This situation develops most frequently in chronic pyelonephritis, where the distal part of the nephron is most affected. An extracellular K deficit is present in familial periodic paralysis.

Signs and Symptoms of K Abnormalities

Potassium is involved in neuromuscular and cardiac function. Intoxication, or high blood K, leads to mental aberrations and finally to convulsions. Reflexes become hyperactive at first but later diminish and finally disappear in severe cases. Ventricular fibrillation or ventricular standstill may occur. The electrocardiogram begins to show high peaked T waves at a level of 6.5 to 7.0 mEq. per liter. Later the P waves disappear, and eventually there is marked widening of the QRS complex, followed by ventricular fibrillation or standstill. The EKG is about 95 per cent accurate in the diagnosis of potassium intoxication.

Potassium deficiency produces mental aberrations, drowsiness and extreme weakness, eventuating in a complete flaccid paralysis. Paralytic ileus may be seen even in moderate cases. Congestive heart failure and acute pulmonary edema may occur, particularly if sodium is present in excess. The reflexes usually disappear.

Diabetic Acidosis

As much as half of the intracellular K may be lost in diabetic acidosis. Since the loss of water exceeds the loss of potassium, in many instances the blood concentration is high and the EKG may show K intoxication. As fluids are given, the potassium is diluted, and also it enters the cell with glucose under the influence of insulin so that the blood level becomes low. At this time fatal deficiency may develop though most patients with diabetic acidosis never exhibit overt signs of deficiency. It is advised that K be given only after some fluid has been administered and then only in severe cases, when the patient cannot take orange juice reasonably early.



Vomiting, Suction, Fistulae and Diarrhea

Here potassium intake or absorption is disturbed, and, because of stress, the urinary loss is increased. Not much is lost through the gastroenteric tract or through the fistula since the concentration in the gastroenteric contents is only eight to 15 mEq. per liter. Dangerous or fatal hypopotassemia may occur in the depleted patient if the depleted patient is given glucose which carries K into the cell. *Strong laxatives* over a period of months have been reported to have caused K depletion. The diarrhea of pancreatic insufficiency can result in fatal hypopotassemia, but only after many months.

Renal Insufficiency

In renal insufficiency all cations or positive ions including K may be lost because of inability of the kidneys to make ammonia and excrete ammonium salts instead of the salts of Na, K and Ca. This occurs most often in chronic pyelonephritis because it damages the distal tubules relatively early. A rare type of K-losing nephritis is seen occasionally causing a specific loss of K.

Treatment of Hypokalemia (Hypopotassemia)

Patients with a urine flow of less than 750 cc. should never receive K except with very careful chemical or EKG control and a specific reason for giving it. It should always be given by mouth if possible, and, if not, subcutaneously or intravenously. Except in unusual circumstances it should not be given at a rate faster than one gm. per hour. In family periodic paralysis, potassium is supposed to shift into the cell and a flaccid paralysis is produced. This is relieved by administration of K.

Hyperkalemia

Hyperkalemia or hyperpotassemia occurs eventually in most cases of persistent oliguria of less than 400 cc. per day or in anuria. It occasionally occurs in renal failure without diagnosis.

As a temporary measure, glucose and insulin may be given to induce the return of K to the cell with the laying down of glycogen. A sodium cation exchange resin given by mouth will absorb the potassium in the gastroenteric fluids and cause it to be eliminated through the bowel. Thorazine, which blocks the vomiting center in the brain, may help the nauseated patient to hold down the resin. Since calcium is also absorbed by

the resin, calcium must be given by mouth or parenterally. Another temporary measure is to use gastric suction and replace the sodium which is removed. The bicarbonate salt of sodium is used if the patient has acidosis. If severe alkalosis develops, dilute HCl or ammonium chloride may be needed.

Peritoneal dialysis may serve for a day or two, but if the potassium is coming out of the cells very rapidly, only the artificial kidney removes K fast enough to save the life of the patient.

1954 POLIO ATTACK RATE IN GEORGIA

THE POLIO ATTACK rate in Georgia in the year just ended was about 15 per cent lower than the national average, according to provisional reports. Nationwide, the number of cases reported in 1954 was the third highest on record.

Yet some counties in Georgia had high polio attack rates in 1954. For example, DeKalb County's attack rate was more than twice the national average. It is impossible to predict where and when polio epidemics will strike, which underlines the need for more effective control measures.

Evaluation of the Salk vaccine, administered to 440,000 U. S. children, in the largest medical experiment of its kind ever conducted, is now in progress. Announcement of the vaccine's effectiveness will be made in the Spring.

It is hoped that Georgia physicians will support the 1955 March of Dimes as enthusiastically as approximately 20,000 physicians throughout the United States cooperated in the 1954 vaccine field trials sponsored by the National Foundation for Infantile Paralysis.

This year the March of Dimes must do a bigger job than ever before. It must raise \$64,000,000—because \$9,000,000 is needed to purchase vaccine, \$2,700,000 for scientific research, \$2,900,000 for professional education, and at least \$29,900,000 for patient aid, including hospitalization. The March of Dimes has expended \$203,600,000 in patient aid since 1938.

Let your patients and friends know that the March of Dimes fights wisely, economically and effectively against the polio threat.



Cancer of the Rectum and Rectosigmoid

A. B. CONGER, M.D., Columbus, Ga.

CANCER OF THE rectum and rectosigmoid is very common, presents early symptoms, is easily diagnosed and offers perhaps the best chance of cure of any of the internal cancers. *In a majority of instances, when a cancer of the rectum kills, it does so not because it didn't call attention to itself and not because of surgical inadequacies, but because either the patient or a doctor ignored the fact that a cancer could be present.*

It has been stated by Rankin and Graham¹ that carcinomas of the colon comprise approximately 15 per cent of all carcinomas. Some 64 per cent of the carcinomas, or roughly two-thirds, are in the rectum or rectosigmoid¹. And Rankin² has stated that about half of the carcinomas of the colon are low in the rectum.

There is no such thing as a silent cancer of the rectum or rectosigmoid. On the contrary, symptoms are early and, in almost every instance, profound enough to be noticed and worried about by every patient except maybe those in mental institutions. These early symptoms are those of irritation of the bowel, manifesting itself in diarrhea, and bleeding from the anus. The late symptoms of progressive constipation, or alternating constipation and diarrhea, or obstruction, or perforation or wasting, etc., are interesting, and of course make the diagnosis apparent without even a physical examination. *But in every such case either the patient or the physician ignored earlier symptoms.*

The diagnosis of carcinoma of the rectum or rectosigmoid is the easiest to make of all the internal cancers. In over 50 per cent of the cases it requires only a rectal examination, and in 100 per cent of the cases it requires only the use of an anoscope or sigmoidoscope with the biopsy forceps. In many instances either of these latter

procedures can be done at the initial visit without preliminary cleansing of the lower bowel. If negative, the procedure should be repeated later after the lower bowel has been adequately prepared. Every patient who complains of any bleeding from the anus of any kind, or any change in bowel habits, should be subjected to such an examination.

The prognosis in carcinoma of the rectum and rectosigmoid has been reasonably good since the introduction of the Miles' procedure some 40 odd years ago. In 1931, Miles³ followed a group of 94 patients who had survived abdomino-perineal resection for carcinoma of the rectum and found 69 alive and well at the end of five years. This is a nonrecurrence rate of 73.3 per cent. These figures are still hard to beat. However, the operability rate and mortality rate have become dramatically better in the past 20 years. In 1929, Jones⁴ reported 22.7 per cent mortality in a series of 204 cases of carcinoma of the rectum in which the patients were treated by abdomino-perineal resection. At the Lahey Clinic⁵ since 1936, the operability rate has increased from 62 per cent to 83 per cent while the mortality rate has dropped to 3.8 per cent in 1941, and 6.2 per cent in 1945.

The treatment of carcinoma of the rectum or rectosigmoid is radical surgery. There has been a great deal of interest in the extension of the accepted standard resections for cancer, such as ligation of the inferior mesenteric artery at its source, pelvic lymph node dissection and a wide perineal excision.⁶ These are of some importance and will find their proper places in the surgical armamentarium. Of major importance also in the prognosis and treatment of cancer of the rectum and rectosigmoid is the particular grade of the cancer. However, by far the most important factor is early diagnosis and early treatment.

The following two recent cases are presented to reemphasize certain factors.

CASE REPORT

Case No. 1 (SFH No. 17134) was a 46 year old male who was first seen 8-11-54, for a routine insurance examination. In the course of questioning it was noted that he had lost some 30 pounds in the past six months and that the weight loss had been accompanied by abdominal pains, especially in his epigastrium, and by "mucous in his stools." His earliest symptom was diarrhea. He was seen by his local physician in South Carolina and treated for "ulcers." Later when symptoms persisted, he received a gastrointestinal series and a barium enema, both of which had been negative.

Because of the patient's desire to be treated in Columbus, and his desire also to get back home as soon as possible, he was admitted to St. Francis Hospital the same afternoon he was originally seen, with a diagnosis of carcinoma of the gastro-intestinal tract. Because of the patient's insistence on hurrying and because most radiologists feel it is impossible to adequately examine a colon within a few hours of sigmoidoscopic examination, a barium enema and x-ray of the chest were done on 8-12-54, both of which were negative. A gastro-intestinal series was done 8-13-54, and this also was negative. He was discharged from the hospital on 8-14-54, but was seen in the office at a convenient time the same afternoon. A sigmoidoscopic examination revealed a large, fungating carcinoma of the rectosigmoid some 13 cm. up the rectum in just the correct position to be hidden by a redundant loop of sigmoid. A combined abdominoperineal resection was done on 8-25-54. At the time of surgery there was no evidence of metastases to the liver or omentum. The carcinoma was tremendously large, had extended to the mesentery and was stuck to the pelvic wall on all sides. A radical resection was done with a great deal of difficulty, in the hope that some of this tissue might be inflammatory rather than carcinomatous. The pathological report was grade II adenocarcinoma. The post operative course was uneventful until 10-8-54, some two months after the original operation when a mass was noted beneath the abdominal scar. This was resected and revealed metastatic carcinoma. Since this

time many masses can be felt in his abdomen.

Comment: If this patient had had a sigmoidoscopic examination some six months before he did, he would have had an excellent chance of survival. A barium enema is no substitute for a sigmoidoscopic examination.

CASE REPORT

Case No. 2 (CCH No. 7635A) was a 61 year old white male who was first seen in the office of a local physician on about 9-18-54. He had been followed for several months because of angina, but this time he complained of some bleeding from his rectum. A sigmoidoscopic examination was done, and a very small carcinoma of the rectum was found some nine cm. above the sphincter. He was referred to us and a combined abdomino-perineal resection was done on 9-30-54. The patient was discharged on 10-12-54; he returned to work well healed and strong on 11-3-54.

Comment: Because of the alertness of this patient's physician and his use of the sigmoidoscope, this patient has a very excellent chance of survival. He will be followed closely. Every six months an examination with the sigmoidoscope and barium enema will be done through the colostomy because of the known tendency of carcinoma of the colon to be multiple.⁷

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Postgraduate Cardiovascular Program Offered

A postgraduate cardiovascular research and training program is offered by the Departments of Physiology and Pharmacology, Medical College of Georgia, Augusta. The twelve months program is supported by the National Heart Institute, U.S.P.H.S., and the American Heart Association, and is under the direction of Dr. W. F. Hamilton, Professor of Physiology and Dr. R. P. Ahlquist, Professor of Pharmacology.

Graduates in medicine or related sciences who are highly recommended and acceptable to the program Directors will be appointed for one year, effective July 1, 1955, to the faculty rank of Research Associate. The stipend will be \$3400, plus \$350 for each dependent. First class transportation for the appointee, but not his dependents, will be provided from his home or institution of residence to Augusta. For foreign appointees transportation from point of entry will be furnished.

ed. Return transportation is not provided.

This program is intended to accelerate the development of available qualified personnel for research in cardiovascular problems and to provide the opportunity for independent research and publication in this field. A formalized course is available which includes the following: technical training in various research methods employed on man and animals; assisting qualified investigators in basic research, members of the Departments of Physiology, Pharmacology, Thoracic Surgery and Medicine will head such research groups; supervised experience in independent research and manuscript preparation will conclude the training program.

Queries or requests for application forms should be addressed to either Dr. W. F. Hamilton or Dr. R. P. Ahlquist, Medical College of Georgia, Augusta, Georgia.



Psychosomatic Heart Disease

ARTHUR M. KNIGHT, JR., M.D., Waycross, Ga.

PATIENTS PRESENTING the entities considered under this label do not usually have organic heart disease, but the personality is sick. The patient may also have psychosomatic symptoms arising in other systems. Most of such patients are suffering from some type of psychoneurosis.

The patient with an anxiety neurosis suffers from a state of apprehensive tension characterized by a frequently recurring feeling that something bad is going to happen. This often becomes very acute in attacks in which he is aware of such manifestations as sinus tachycardia, premature systoles, hyperpnea, sweating, tremor and weakness. Because his emotional conflict is on an unconscious level, he is aware only of these somatic symptoms. The effort syndrome is a manifestation of an anxiety state.

Hysteria may also produce cardiovascular symptoms which have some obscure, symbolic and unconscious meaning for the patient. In such cases the "heart disease" serves some useful purpose in the patient's life, such as protecting him from the necessity of meeting his responsibilities.

Tension and fatigue often cause premature contractions and a sense of pressure or of a "load on the chest". Neurotics are often weak and blame it on a "weak heart" or on "low blood pressure". Depressed people often feel "bad all over" and sometime suspect heart disease as the cause. Cardiovascular symptoms in neurotic patients often begin soon after the death of a relative or close friend from a coronary occlusion.

Strong emotion such as anxiety can influence cardiovascular functioning profoundly, producing such symptoms as sinus tachycardia, premature systoles, runs of premature systoles, paroxysmal tachycardia and even paroxysmal auricular fibrillation. Emotional tension can precipitate attacks of angina pectoris and acute pulmonary edema; it can elevate blood pressure. Other respiratory symptoms, such as sighing respirations and hyperventilation, are due to emotional influences, and the patient often interprets them as indicating heart disease.

Physicians too often serve as etiologic agents in the production of psychosomatic heart disease.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

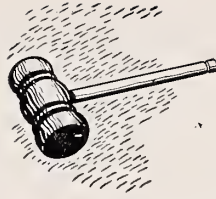
The doctor is a trusted and respected authority, and the neurotic patient is often highly suggestible. Therefore, the statements of the doctor are likely to have a profound psychological impact on the thinking of the patient. If the doctor mistakenly states or hints that such a patient has heart disease, the patient is liable to be convinced that this is true. Afterwards, it will be very difficult for anyone to convince him that his heart is normal. For this reason, it is most important for us to choose carefully the words we use in explaining symptoms to patients. For example, it is extremely poor judgement to refer to a paroxysm of tachycardia as a "heart attack".

To tell a patient that he has a "nervous heart" is also poor judgement, because this places the emphasis on the somatic rather than the psychological aspect of the illness. One should try to help the patient understand that it is his personality which is sick, not his heart.

One should never call the patient's attention to his heart murmurs. If the doctor is not certain that a patient has heart disease, he should scrupulously avoid making undesirable suggestions to the patient, and he should refer him, with much reassurance, to an internist, a cardiologist or one of the free heart clinics.

The patient with a cardiac neurosis deserves a thorough history, complete physical examination, adequate laboratory studies, a chest x-ray and an electrocardiogram. This will convince him that he has been adequately studied and will support the reassurance his doctor gives him. It will also find the occasional neurotic who has organic heart disease as well as functional symptoms.

The doctor who takes time to become acquainted with each patient as a person will find it easy to recognize psychosomatic heart disease by allowing him to discuss his family life, business and financial worries, marital difficulties, love life, sexual problems, anxieties, fears and other emotional symptoms. Such a survey also has considerable psychotherapeutic value. Obstinate or difficult cases should be referred without hesitation to a psychiatrist, but, when this is done, every effort should be made to make the patient understand that it is being done in a sincere spirit of trying to relieve him of his suffering.



president's page

As we come to the beginning of 1955, I wish to take this opportunity of wishing each member of our profession a very Happy New Year.

It is also my wish to stress the fact that the most urgent problem confronting the medical profession today is the encroachment upon organized medicine by Government financed, Government operated or Government controlled groups and organizations. In other words, socialized medicine in its various and varying forms constitutes a real menace to organized medicine.

Unless the medical profession more strongly unites and fights for the principle that each individual member is a free and independent practitioner, whose prime duty is to the patient, and strongly resents hindrance or control by any governmental group and that the practice of medicine follows a plan according to the dictates of their own conscience, organized medicine is bound to come to an end within an alarmingly short time.

Any physician who accepts a salaried position in a Government controlled institution which exploits his professional services to the detriment of private physicians not only violates the Code of Ethics of the A.M.A. but can no longer be considered a free and independent practitioner, but a Government employee. No matter how he may rationalize the situation to salve his conscience, he has sold his birthright to exercise his own free judgment in the treatment of patients and has agreed to a control of that judgment by others whose chief interests may not be best for the patients.

Constantly proposals are made and pressure exerted to force practitioners to sell their professional birthrights.

Unless organized medicine, as we know it, resists these pressures as individuals and as members of our professional societies, organized medicine is doomed; the individual practice of medicine is doomed; and the creeping socialism of the past quarter of a century will stand triumphant over the remains of a once great profession.

It is my sincere hope that the medical profession of Georgia will stand out prominently and set the pace against socialized medicine.

Unusual Cases of Aortic Insufficiency

HUGH K. SEALY, M.D.,* Macon, Ga., J. WILLIS HURST, M.D., Bethesda, Md.,
and R. BRUCE LOGUE, M.D., Emory University,

THE MOST COMMON cause of aortic insufficiency is rheumatic heart disease. Syphilitic heart disease, so prevalent in the past, is rapidly vanishing. Systemic hypertension of a severe degree produces aortic insufficiency in a small percentage of patients. It is not commonly appreciated that aortic insufficiency can result from a number of additional disease states. The purpose of this report is to emphasize the less common (or unusual) causes of aortic regurgitation.

I. Aortic Insufficiency Due to Bacterial Endocarditis.

W.M., a 35-year-old white male, was admitted to Emory University Hospital because of fever and pain in his legs for 3½ months. One month

previously he had been seen elsewhere, and the examination of his heart and chest X-rays was normal. Blood cultures were negative. Pulses were absent in the feet, and a diagnosis of thromboangitis obliterans was made. The patient was referred to Emory Hospital for sympathectomy. On admission he was found to have an aortic diastolic murmur and the peripheral signs of aortic insufficiency. The heart was found to be enlarged on physical examination and by X-ray studies (See Fig. 1.). He had a persistent temperature elevation of one to two degrees. Blood cultures were positive for enterococcus, and the diagnosis of bacterial endocarditis was made. The administration of 21 million units of penicillin intravenously and 1.5 grams of streptomycin intramuscularly daily was started. He became afebrile within 48 hours. Therapy was continued for three weeks and blood cultures obtained at the termination of antibiotic therapy were negative. Three weeks

Presented at the 104th Annual Session of the Medical Association of Georgia, Macon, May 2-5, 1954.

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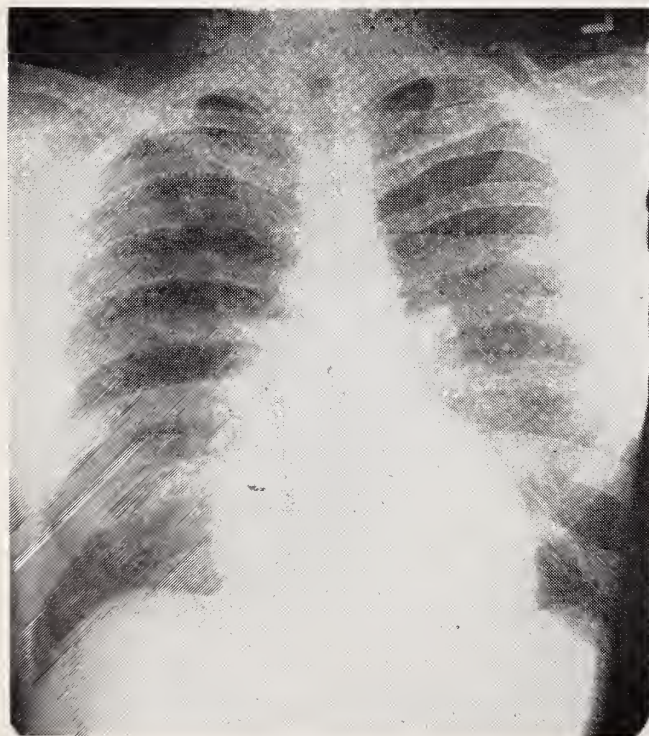


Figure 1 A

This X-ray was made on January 4, 1953, and shows moderate cardiac enlargement.



Figure 1 B

X-ray of chest six weeks later shows marked increase in heart size and pulmonary congestion.

after discharge from the hospital he developed congestive heart failure. He became progressively worse and died six weeks later of intractable heart failure. At autopsy a congenital bicuspid aortic valve with vegetations along the free margin was found. There was no evidence of active bacterial endocarditis. (See Fig. II).



Figure II

Autopsy specimen which shows the bicuspid aortic valve with large vegetations along the valve margin. There is scarring and distortion of the valve.

COMMENT: Aortic insufficiency may be a clue to the diagnosis of bacterial endocarditis. In this patient the underlying heart lesion was a bicuspid aortic valve which had been asymptomatic. He was admitted for operative therapy for what was thought to be peripheral vascular disease. The diagnosis of bacterial endocarditis was not made until he developed aortic insufficiency and attention was focused on the heart.

Aortic insufficiency is an ominous sign when appearing during the course of bacterial endocarditis. In this patient, although the infection was later cured, the appearance of aortic regurgitation indicated the beginning of his terminal illness. Congestive heart failure is the cause of death in about 20 per cent of the fatal cases of bacterial endocarditis and is more common when aortic insufficiency occurs due to aortic valve involvement.^{1 2 3 5} Such regurgitation is the result of erosion with subsequent scarring of the valve. Occasionally this process produces an actual hole in the valve.

II. Aortic Insufficiency Due to Dissecting Aneurysm.

J. S., a 59-year-old white male, had sudden onset of severe chest pain accompanied by paralysis of the left leg and rapidly developing coma one hour before admission to Emory University Hospital. Previously he had not been known to

have heart disease. On admission the blood pressure in the left arm was 170/55 and unobtainable in the right arm. The right radial pulse was absent, but the other peripheral pulses were full and bounding. Along the left sternal border the diastolic murmur of aortic insufficiency was heard. The patient's condition continued to deteriorate, and he died 20 hours after admission. At autopsy an extensive dissecting aneurysm of the aorta was found. There was no intimal tear and the dissection extended to the aortic ring.

COMMENT: Aortic insufficiency appearing with the sudden onset of severe chest pain is almost pathognomonic of *dissecting aneurysm*.^{6 7 11 12} It is important to differentiate dissecting aneurysm from myocardial infarction antemortem as the prognosis is much worse, and anticoagulant therapy would be contraindicated in patients with dissecting aneurysm. About 50 per cent of the patients with dissecting aneurysm will be found to have the murmur of aortic regurgitation, and it is an important sign in the differentiation of the two conditions.⁷ Likewise in a patient with an aneurysm of the aorta, a negative Kahn and aortic insufficiency, the diagnosis of chronic dissecting aneurysm should be suspected.^{10 11} There have been several explanations advanced for the mechanism of production of the aortic diastolic murmur. They are (1) regurgitation of blood through the intimal tear,¹² (2) stretching of the aortic ring by the aneurysm,¹³ (3) a cusp drops inferiorly as the dissection loosens the intima and removes support for the valve,¹⁴ and (4) a downward displacement of the valve by a hematoma.¹⁴

In patients with Marfan's syndrome (arachnodactyly) there may be local dissection of the aortic root producing aortic insufficiency.¹¹ The aneurysm may not be found on clinical or X-ray examination, but the insufficiency produced may be of a degree to result in severe congestive failure and death. We have observed one such case in a 28-year-old white female.

III. Aortic Insufficiency in Luetic Valve Disease With Intermittent Retroversion of an Aortic Cusp

R. W., a 43-year-old colored male, was seen at the Cardiac Clinic at Grady Memorial Hospital in 1947 because he had noticed a loud humming noise in his chest for one year. This noise had, on occasion, been loud enough to be heard by his friends seated several feet away. Fourteen months previously he had been found to have a positive Kahn and had received penicillin therapy. On

examination a loud, musical, cooing, aortic, diastolic murmur was heard over the entire precordium. This murmur was characteristic of a retroverted aortic valve cusp. The peripheral signs of aortic insufficiency were present. The cooing murmur had been present for months at a time only to disappear completely and then recur. He had had congestive failure, but the severity seemed to have had no relationship to the presence of the cooing murmur. By X-ray examination the left ventricle was markedly enlarged.

COMMENT: Retroversion of an aortic cusp can result from acute rheumatic fever but is much more common in *luteal valve disease* and produces a high pitched, cooing, aortic, diastolic murmur. A similar murmur may be produced by a ruptured cusp or a valve deformed by the vegetations of bacterial endocarditis. Several factors have been suggested as important in producing a retroverted cusp. They are: (1) sagging of a free edge due to widening of a commissure which produces a long, narrow valve; (2) loss of elastic tissue support of the valve cusp; (3) thickening of the free edge which allows it to turn back on the valve beneath.^{17 18} The anterior cusp, which is less well supported than the other cusp, usually retroverts. Retroversion of a cusp is an ominous sign which usually ushers in severe congestive failure and an early death. This was not true in this patient who has been doing well for seven years after retroversion. Retroversion of an aortic valve cusp due to Lues is not unusual, but *inter-*

mittent retroversion of a cusp is rare, and there is no mention of a similar case in the recent literature.

IV. Aortic Insufficiency Due to Penetrating Trauma of the Chest.

G. D., a 29-year-old white male, received shrapnel wounds of the chest during World War II. One week after injury he developed a hemopericardium and an elevated temperature. He was treated by pericardiocentesis and with penicillin with apparently good results. Forty-one days after injury he had sudden onset of chest pain and dyspnea. For the first time he was found to have a loud, diastolic murmur and softer systolic murmur in the aortic area with the peripheral signs of aortic insufficiency. These persisted, and he developed left ventricular hypertrophy and congestive heart failure. Chest X-ray showed a metallic foreign body in the region of the root of the aorta which could be seen to pulsate vigorously with each heart beat. (See Fig. III). A pulmonary-aortic fistula was considered unlikely because of the absence of increased pulmonary flow on X-ray and because the clinical findings were more typical of aortic insufficiency. Cardiac catheterization was done, and there was no evidence of a right to left shunt.

COMMENT: The occurrence of valve lesions with survival from penetrating wounds of the heart is rare. We could find only four instances



Figure III A

PA film of the chest which shows slight left ventricular hypertrophy. The foreign body cannot be seen as it overlies a vertebra.



Figure III B and C

The large metallic foreign body can be seen to lie in the region of the root of the aorta.

among 324 cases of penetrating wounds of the heart reported in the recent literature and only two of these lived longer than one year.²⁰⁻³³ The pathogenesis of the aortic insufficiency in this patient is not known. There are three possibilities. (1) Direct trauma to the valve could have occurred, although it seems unlikely. Had this been the case, the aortic insufficiency should have been found immediately after injury rather than 41 days later. (2) Destruction of the valve by bacterial endocarditis is more likely. The missile was surely infected, and the febrile course would fit well with the clinical picture of bacterial endocarditis. Harkin has produced valve damage by experimentally implanting infected foreign bodies and producing bacterial endocarditis.³⁴ (3) Erosion of the valve by impingement on a fixed foreign body during its normal range of motion is also a possibility. This has been shown to occur experimentally by Swann, et al.²³ In this patient the foreign body is fixed in such a position that this could have happened.

V. Other Unusual Causes of Aortic Insufficiency.

Non-penetrating trauma may produce a ruptured valve.³⁵ The trauma in such cases is usually a severe crushing blow or a fall of a great distance. The murmur produced by a ruptured cusp is a cooing murmur similar to that occurring with retroverted cusps. Ruptured valves from non-penetrating trauma occur more commonly than damage produced by penetrating wounds of the heart.

Aortic regurgitation may be found in patients with Eisenmenger's complex. At autopsy the cusp which lies just above the septal defect has been described as lying at a lower level than the other cusps.³⁷⁻³⁸ This results in an insufficient valve.

Coarctation of the aorta may also be accompanied by aortic insufficiency. There are several causes for the aortic regurgitation in these patients. (1) There may be stretching and dilatation of the valve ring by the hypertension present. (2) A congenitally deformed valve (usually a bicuspid valve) may undergo degenerative changes.⁴³ (3) Coarctation associated with congenital subaortic stenosis and insufficiency has been described as a syndrome.³⁹ It is interesting that patients with coarctation and aortic insufficiency will show peripheral signs of aortic insufficiency only in the head and upper extremities.

Non-rheumatic calcific aortic valve disease may produce such rigid and deformed cusps that they do not approximate during diastole and thus produce regurgitation.⁴² Occasionally aortic regurgi-

tation without signs of aortic stenosis has been described when the only lesion was calcific aortic valve disease.

Conclusions

Unusual cases of aortic insufficiency due to bacterial endocarditis, dissecting aneurysm of the aorta, intermittent retroversion of a valve cusp and penetrating wound of the chest have been presented. Other unusual causes including Marfan's syndrome, non-penetrating chest trauma, Eisenmenger's Complex, coarctation of the aorta and non-rheumatic calcific disease of the aortic valve have been discussed.

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AMA "Videclinic" to Be Presented

"Videclinic"—a special closed-circuit television program to bring new advances in medicine to physicians quickly will be presented coast to coast on February 9 by the American Medical Association.

Dr. George F. Lull, secretary-general manager of the A.M.A., has announced the program. The telecast is expected to be viewed by nearly 18,000 doctors in at least 30 cities, the largest single closed-circuit television audience of its kind.

In making the announcement, Dr. Lull said this program will bring the full array of modern television techniques—live television, "remote pickups" from medical centers, and adequate film coverage—to the service of medical education for the first time.

Projected as the "Medical Journal of the Air," the new program will visually demonstrate new advances in medicine and will help bridge the gap between the time a scientific paper is presented at a medical meeting and the time it comes to the attention of the practicing physician through normal publication channels.

The program, presented by the American Medical Association in cooperation with Smith, Kline

& French Laboratories, a Philadelphia pharmaceutical house, will be shown at 8:30 p.m. E.S.T., Wednesday, Feb. 9. It will be telecast over the "Telesession" facilities of Theater Television, Inc., New York.

The local county medical society will be invited to act as host in each city where the telecast is scheduled for showing in hotel auditoriums.

The program will concern heart disease, a problem of increasing importance to our aging population.

"Medical progress is accelerating at a tremendous rate," Dr. Lull said. "Only by grasping the new communications opportunities such as closed-circuit television can the physicians of this country keep abreast adequately with all the new advances.

"Complete clinical presentations of patients and techniques are needed for this critical medical education job, not simply lectures or panels. For example, when the discovery of cortisone was announced it caused a deluge of questions. What a wonderful thing it would have been to have used closed-circuit television as a means of instantly relaying this life-saving information to the nation's doctors."

A Review of 75 Intracranial Aneurysms

LOUIS A. HAZOURI, M.D., Columbus, Ga.

THE PROTOCOLS of verified intracranial aneurysms were reviewed. This included those cases proven by autopsy examination, intracranial surgery or by angiographic demonstration. Many classical papers are written about the etiology, surgical methods of therapy, angiography and other allied subjects to the necessity of practical exclusion of their discussion from this paper.^{1 2 3 4} Suffice it to say that intracranial aneurysms were probably first recognized by Morgagni in the year 1761, and the recent progress made in the study of intracranial aneurysms has been improving steadily.¹

Material

Some 164 cases classified as subarachnoid hemorrhage, etiology undetermined, were present. These cases covered a period beginning in 1930 and extending through 1951. No attempt was made to analyze these cases for this paper. Hospital files of 63 cases with proven intracranial aneurysms were examined; the files included their respective necropsy reports. Two cases are included in this study which have been proven by angiography, but death occurred without permission to examine the brains. Seven cases have aneurysms proven angiographically and are living. This series then consists of 72 patients with verified aneurysms. Two additional cases of particular interest are mentioned in this paper although they had no intracranial aneurysms.

Among the many cases excluded from this study were those post mortem specimens whose findings were considered to be equivocal. Arteriovenous fistulae between the carotid artery and cavernous sinus, of which there were three, and two cases of surface anomalies involving the middle cerebral artery complex were not included in this paper. Two cases of lobe hemangioblastomata with subarachnoid hemorrhage were reviewed but not included in the statistics of this paper. One case of microscopic angiomatous formation, which

could have been the etiological factor in the production of an intracranial hemorrhage, is not included, although it is believed that the number would have been higher had the knowledge of such a contribution been available during the accumulation of the greatest portion of the material for this study.⁵

There were eight cases whose symptomatology and findings were considered "sufficient" to make the diagnosis of intracranial aneurysmal leakage. These cases were treated by large vessel ligation in the neck. Exclusion of these cases was made since no verification of aneurysm was found. Correlatively, many cases of subarachnoid hemorrhage were assigned the diagnosis of intracranial aneurysm, but again definite proof of their existence by the criteria of selection set up above necessitated their exclusion.

Analysis

The 72 protocols examined revealed a total of 75 aneurysms. One case was found to have multiple aneurysms, a percentage of 1.3, a much lower figure than that of 15 per cent cited by Dandy.¹ This same case presented mirror image aneurysms on the left anterior cerebral and middle cerebral arteries and the right anterior cerebral and middle cerebral arteries, an observation originally described by Courville.³

Eleven aneurysms were not ruptured, a percentage of 14.3. These were unrelated to the cause of death with several exceptions. The first was an unruptured aneurysm of the basilar artery which presented symptoms of progressive bulbar palsy of three years' duration. Post mortem findings revealed a pressure defect with much thinning of the pons and medulla, and the vertebral arteries were so displaced as to be embedded in the cerebellar substance. The other case was that mentioned above with mirror aneurysms in which one of the aneurysms had ruptured.

The distribution of aneurysms was as follows:

FIGURE ONE
SITE OF ANEURYSM BY VESSEL

ARTERY	Number	Percentage	McDonald and Korb	Dandy
Anterior communicating	10	15.1 %	23 %	18.8 %
Anterior cerebral	18	27.2 %	23 %	18.8 %
Internal carotid	8	12.1 %	19 %	44.2 %
Middle cerebral	14	21.2 %	29 %	19.5 %
Posterior communicating	5	7.5 %	10 %	0
Posterior cerebral	1	1.5 %	21 %	1.5 %
Basilar	7	10.6 %	21 %	15.8 %
Vertebral	2	3.0 %	21 %	15.8 %
Posterior inferior cerebellar	1	1.5 %		

10 were present on the anterior communicating, eight on the internal carotid, 14 on the middle cerebral, five on the posterior communicating, one upon the posterior cerebral, seven on the basilar, two on the vertebral and one on the posterior inferior cerebellar artery. Aneurysms which arose at the junction of vessels, precluding their precise origin, totaled nine. Two cases presented aneurysms at the junction of the internal carotid artery and posterior communicating artery. Two cases had aneurysms at the junction of the anterior communicating and anterior cerebral arteries. The junction of the internal carotid and the middle cerebral arteries presented aneurysms in two patients. One aneurysm was present at the junction of the internal carotid and posterior cerebral arteries, and one aneurysm was present at the junction of the middle cerebral and posterior communicating arteries.

Reference is made to the tabulation for comparative percentages with two authors. (Fig. 1). Since nine cases in this series did not present the precise origin of the aneurysms, the percentage is based on 66 aneurysms.^{1 6}

A classification of aneurysms into congenital, arteriosclerotic and mycotic was used. Several cases were suspected of being syphilitic in origin, but syphilis as a definite etiological basis could not be established. The evidence for such a classification as to etiology has been convincing.^{2 6} Forty-four cases were congenital in origin, a percentage of 64.7. Twenty-two cases or 32.9 per cent were arteriosclerotic in origin, and two cases or 2.9 per cent were mycotic in origin. In a series of 30,000 autopsies, Courville found 83 cases of congenital origin and 12 aneurysms of arteriosclerotic origin.³ In the monograph written by

Dandy, 16.2 per cent were arteriosclerotic in origin and 4.5 per cent were mycotic aneurysm.¹

The occurrence of intracranial aneurysms with anomalies of the vascular system has been noted in the literature.^{7 8} In this analysis only one case was found, that of an unruptured aneurysm of the left vertebral artery. This patient died of unrelated causes and was found to have a coarctation of the aorta at the level of the third dorsal vertebra. In a review of coarctation of the aorta reported by Hearne, vascular complications were found in 13 per cent.⁸ Hamby suggests that the association of intracranial aneurysm and coarctation of the aorta is evidence for the congenital origin of intracranial aneurysms.⁶

Traumatic rupture of an aneurysm has been relatively infrequent with the exception of arteriovenous fistula between the cavernous sinus and the internal carotid artery.⁶ In only two cases of this series could trauma be associated with arachnoid hemorrhage secondary to ruptured intracranial aneurysm. There is evidence to support the opinion that trauma is the cause of subarachnoid hemorrhage, secondary to ruptured intracranial aneurysms, and there is evidence to support the opinion that the spontaneous rupture of an aneurysm results from trauma.

A patient who had four attacks of spontaneous subarachnoid hemorrhage and survived with a large subdural hematoma was described by Dandy.¹ Whether this patient suffered from a subdural hematoma secondary to bleeding intracranial aneurysm or to other causes is not clear. A group of five cases in this series was found to have a subdural accumulation of blood which could be considered a surgical clot. These clots

originated from ruptured aneurysms of the anterior communicating artery in two cases, the anterior cerebral artery in two cases, and in one case, from an aneurysm at the junction of the internal carotid and posterior communicating arteries. One of these five cases was associated with trauma at the onset of the subarachnoid hemorrhage, again whether the subdural accumulation was secondary to trauma or to ruptured aneurysm can be only a matter of speculation. The most plausible explanation for subdural clots of surgical significance in these cases is the forceful outpouring of blood from the ruptured aneurysm with resultant tear of the arachnoid membrane and a sanguinous accumulation in the subdural space. Many factors enter into the final plane of dissection of the extravasated blood. It would appear that the proximity of aneurysm and its parent vessel to cerebral structure, with or without erosion of the adjacent pia of the vessel's course through the subarachnoid space to its destination, are of the greatest importance in the end result of aneurysmal rupture.

Definite clinical syndromes could not be formulated from the case material reviewed. Exceptions to this were those aneurysms of the intracavernous segment of the internal carotid artery associated with third nerve palsy. Though not included in this review, arteriovenous fistula between the carotid artery and cavernous sinus provided the second exception.

The onset of subarachnoid hemorrhage was sudden in 52 cases and slow in onset in seven cases. Loss of consciousness introduced the attack in 38 patients. Third nerve palsies initiated the onset in seven cases. The onset of hemiplegia occurred in two cases and focal Jacksonian convulsions in another. One case had a history of spontaneous laughter and crying associated with aneurysm of the anterior communicating artery.

Martin has reported four cases having spontaneous laughter: two of these had subarachnoid hemorrhage; one case was presumed to have subarachnoid hemorrhage; and the fourth case was not clarified since post mortem examination was denied.⁹

An analysis of the number of episodes of subarachnoid hemorrhage was made. One patient had multiple recurrences during hospitalization. Percentages computed on the basis of 63 patients presented a death rate of 46 per cent during the first attack, 26.9 per cent during the second episode, 11.1 per cent during the third episode, 9.2 per cent during the fourth attack, and the fifth and sixth attacks had 4.6 per cent and 1.5 per cent respectively. Recurrence rates in the seven cases who are living show four patients having only one attack, two patients, three episodes and one patient having four attacks of subarachnoid hemorrhage. The unusually low number of patients surviving in this series, as compared to other series, must be attributed to the selection of cases with proven aneurysmal demonstration for this material.⁶ (Fig. 2).

The findings recorded on admission or during hospitalization were in general agreement with other reports with a few exceptions.⁶ Only one patient survived in a series of 11 patients who had generalized convulsions. Extraocular muscle paralysis or pupillary changes consisting of unilateral dilatation with fixation or miosis were recorded in 28 patients. Weakness of a limb was observed 18 times and paralysis in 21 cases. In those records describing neck signs, 38 patients had nuchal rigidity and eight patients had supple necks to active flexion. The level of consciousness was recorded 53 times. Those patients who did not respond to painful stimuli numbered 25. Alertness in 10 patients and a state of stupor or confusion in 14 other patients was recorded. Four patients

FIGURE TWO
DEATH AND SURVIVAL RATES

	Present Series	New York Hospital	Magee	Buffalo Gen. Hospital
Patients	63	46	150	130
Death with first attack	46%	11%	35%	39.9%
Death with recurrent attack	53%	22%	21%	28.5%
Recurrent attacks	48.6%	55%	33%	35.4%
Survival rate	11%	67%	44%	36.9%

who are living were described as having no impairment of consciousness. Abnormal toe responses were recorded 39 times. Thirty-two patients were found who had no abdominal reflexes to examination. No case was described as having subhyaloid hemorrhages on funduscopic examination, but there were 12 patients with hemorrhages in the fundus. Papilledema-like states were recorded in 12 other patients. Optic atrophy was described in one patient. Only one patient had signs of a visual field defect. That only one case presented signs of impairment of the visual fields must not be taken to imply that this is a rare occurrence, since many factors, of necessity, enter into the evaluation of a visual field in a critically ill patient.

An elevation of the blood pressure above 150 millimeters mercury, systolic pressure, or 90 millimeters mercury, diastolic pressure, was associated with 39 patients. There were 24 patients with blood pressures which were not considered to be hypertensive. Seventeen cases or 43.5 per cent of patients with arteriosclerotic aneurysms were associated with an elevated blood pressure. A study of patients with congenital aneurysms revealed 22 or 56.4 per cent as being associated with hypertension. These findings are in accord with other authors who stress that hypertension must be looked upon as more than mere incidental occurrence in cases of spontaneous subarachnoid hemorrhage.⁶

Laboratory and diagnostic studies revealed that 47 patients had lumbar spinal fluid pressures above 200 millimeters of cerebrospinal fluid with nine cases below this figure. The initial lumbar puncture was recorded as bloody in 52 cases, of which 26 cases revealed exanthochromia. Three of the initial lumbar punctures showed clear cerebrospinal fluid. In 21 cases, skull X-rays revealed abnormal findings eight times. Angiography demonstrated the aneurysm in eight cases. Electroencephalographic studies were done so infrequently that they were not recorded in this study.

With the exception of hypertensive cardiovascular disease, the most common diagnoses made in order of frequency were those of cerebral hemorrhage, subarachnoid hemorrhage, ruptured intracranial aneurysm and cerebral thrombosis. Of note is the mania which occurred with the onset of hemorrhage in two cases. The original impression was that of a non-organic disease.

Two cases of particular interest presented findings suspicious enough to warrant an initial diagnosis of intracranial aneurysm. Each case presented at its onset severe trigeminal pain and acute onset of extraocular muscle paralysis. Follow-up revealed one case to have a metastatic carcinoma of the pancreas, and the other, a squamous cell carcinoma of the nasopharynx.¹⁰

In none of the protocols reviewed were there examples of trigeminal tic douloureux as is occasionally seen with aneurysms of the cerebellopontine angle.

An unusual occurrence was that of ruptured aneurysm of the right anterior cerebral artery associated with glioblastosis diffusum and tumor nodule in the corpus callosum. Microscopic hemorrhages throughout the cerebrum were associated with the above.

Of those brains examined at necropsy, the gross pathological diagnosis of arteriosclerosis was made in 34 cases. Eight cases revealed minimal subdural accumulation with five cases mentioned above, revealing the massive accumulation of surgical significance. Subarachnoid staining was observed in all cases of ruptured aneurysm, with dissection of the subarachnoid extravasating blood and occurrence of clot occurring most frequently in one of the following: the Sylvian fissures, the circle of Willis, the interpeduncular fossa, between the frontal lobes and about the base in the posterior fossa.³ Localized cerebral softening, considered by description to be of significant neurological sequelae, was recorded in 24 cases. Generalized cerebral swelling, with obliteration of the sulci and flattening of the gyri were commented upon 44 times. Laceration of cerebral substance occurred in 14 cases, of which the gyrus rectus was involved six times. Intracerebral hemorrhage occurred in 27 cases or 42.8 per cent, with intraventricular hemorrhages occurring 34 times. Several cases were thought to have intraventricular clots secondary to back flow through the fourth ventricle. Of those cases reported by Hamby, 52 per cent had intracerebral hemorrhages.⁶ Shift of the midline structures, interpreted as being of ventriculographic importance had such a procedure been performed, was observed in 16 brains. Uncal herniations occurred 10 times, Kernohan's notch was found in four cases and a cerebellar pressure cone was recorded in 12 cases.

No attempt is made to discuss the therapy of

intracranial aneurysms. Suffice it to say that after careful study of the patient with subarachnoid hemorrhage a positive attitude toward recognition and treatment should be adopted.

Summary

1. The cases of 72 patients with a total of 75 intracranial aneurysms were reviewed.

2. Death occurred during the first episode in 46 per cent of 63 cases. Recurrent attacks occurred in 48.6 per cent of this group, that is, 54 per cent survivors.

3. Five cases of massive subdural hematoma were encountered with a brief discussion as to the etiology of its formation.

4. Intracranial aneurysm was simulated by two cases of carcinoma, one invasive, the other metastatic.

5. The relative rarity of trauma associated with rupture of an intracranial aneurysm is again noted.

6. Eight cases or 11.1 per cent of aneurysmal rupture with profuse subarachnoid hemorrhage revealed no signs of nuchal rigidity on initial examination.

7. Intracerebral hemorrhage was a prominent

post mortem finding in 27 cases, or 42.8 per cent.

8. Gross shift of midline structures which were significant enough to have probably caused a ventriculographic change on X-ray were encountered in 16 cases, or 25.4 per cent.

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"The Man Behind The M. D."

Julian P. Price of Florence, S. C., delivered a paper before the pediatric group at the recent A.M.A. Clinical Meeting in Miami. It was only one of more than 100 papers delivered during the week, but it had an intriguing title: "The Man Behind the M.D."

His paper, in brief, urged physicians to join in a spiritual rebirth within medicine.

From a newspaper standpoint, his talk caught on like wildfire. One of the Miami papers gave it prominence on page one. Several papers, including the Nashville Banner, used it as the basis for editorials. It really rang the bell with the public.

Dr. Price said that in appraising the health of the nation, he believed that "the physical and mental health of our nation is relatively good, but that there is evidence of spiritual disease."

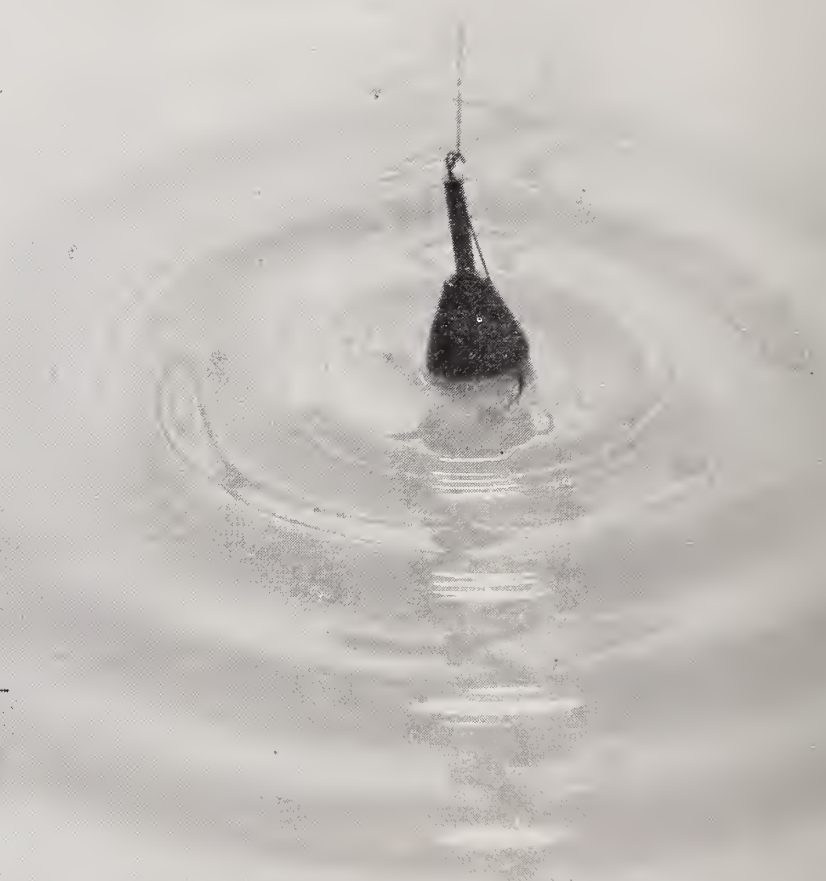
"Since the disease is spiritual," he said, "the treatment must also be spiritual." He added that the symptoms were not hard to find.

Dr. Price listed among them "laxness of morals

in our national government in recent years . . . the hold which organized vice has upon legislative and social life . . . increase in crime in our teenage population . . . bribery and unethical conduct in amateur athletics . . . the mad search for pleasure which causes our people to spend four times as much for beverages as they do for religious and welfare activities . . ."

He called upon his fellow physicians to combat this "disease" by taking part in government, devoting particular interest to public education, working with boys and girls, and charitable and philanthropic organizations, and having healthy, happy homes of their own.

"The only remedy which is of any avail—and to this history bears testimony—lies in a change of heart. It is my sincere belief that the greatest need of our country today—and of our profession—is a spiritual rebirth, a return to God and to his eternal principles. And the rebirth must come in the heart of the average citizen—and in the heart of the average doctor of medicine."



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A Reply to

"The Great Fallacy"

NORMAN F. DACEY, Bridgeport, Conn.

AN ARTICLE WHICH appeared some months ago in this *Journal* is being reprinted and widely distributed by life insurance companies throughout the country. Titled "The Great Fallacy", the article supports the theory advanced by insurance men generally that life insurance is the world's best investment. It brands as a "fallacy" the contrary opinion held by leading financial consultants that life insurance is not truly an investment, that it should be purchased only as protection and that the ideal estate plan is one combining low-cost protection (term insurance) with a prudent program of investment through outright purchase of stocks or through mutual funds.

Quoting liberally from the sales training journal of a life insurance company (hardly an unbiased authority), the author poses the question of why any sensible person should attempt to invest his own money when he can turn the burdensome task over to an insurance company ("The life insurance company eliminates your investment worries") which will "guarantee" him a fixed number of dollars at some future date. Surely the medical profession, the stronghold of individual independence, the last unconquered adversary of regimentation, is the very last one to whom such an argument should appeal. By unconsciously implying that the physician reader lacked both the initiative and the intelligence to handle his own affairs and should meekly surrender himself to the financial ministrations of the benevolent institution of life insurance, the author dealt his entire thesis a severe blow. If there be many in the profession who accept his arguments without careful examination and plan their financial future accordingly, then the author of "The Great Fallacy" will indeed have done the medical profession a great disservice.

His arguments may be summarized briefly as follows:

The author heads Norman F. Dacey & Associates, Financial Consultants and Trustees, with home offices in Bridgeport, Conn.

1. Term insurance is bad because no part of the premiums paid is returnable as cash value.

2. Investment in securities is something which insurance companies can do with complete safety but which individuals can do only with almost certain loss.

3. Through life insurance companies, one may obtain investment services without paying the eight per cent that it would cost, for example, to buy a mutual fund.

4. A tax advantage applicable to insurance proceeds more than offsets any greater return which would be realized by investment in stocks.

Let me try to deal briefly with each of these points in order.

1. There are two basic kinds of life insurance—term insurance, and all other kinds. Term insurance is just protection; the "other kinds" all represent some combination of term insurance plus a savings account. When you buy an ordinary life policy, you pay the premium for term insurance plus an extra amount which the company is to put away for you with the understanding that they are to pay it back to you at age 96. The savings account part of the premium is so computed that, on a \$1,000 policy, it will have accumulated to \$1,000 at age 96. Since the chances of your reaching 96 are about one in 850,000, it is extremely significant that the policy provides that if you die before age 96 (even one day before) the company will pay to your family the \$1,000 of insurance for which you paid them a premium that year—and they'll keep your savings account! No, they won't give your beneficiary your savings account plus the face amount of the policy. During the years until age 96, the company will pay you 2½ per cent interest on the savings account. If you need to use some of that savings account, they'll loan it back to you at six per cent. If you protest that this is not equitable and tell them you have decided to just take your savings account out, the company will punish you by cancelling the protection altogether!

How much better off you would be if you gave them just the term insurance part of the premium and put the rest in the savings bank. By any given date in the future you would have more accumulated in the bank account than you would have in the insurance cash value. The insurance company pays out approximately 15 per cent of everything you pay in your lifetime just for selling the policy, including 15 per cent of the savings account. The bank won't pay anyone for selling you the savings account. Interest will be added to your money, nothing taken from it. After five, or 55 years, you will have more "cash value" accumulated in the savings bank. If you live, then, you are better off. But what if you die? Your family will have *all* the insurance and *all* the money in the savings bank. They'll have *both*—instead of the insurance company's using your savings account to help them pay off the claim. It would appear that by buying term insurance you will be better off if you live, and your family will be better off if you die.

Come to think of it, when you insure your house or your car, you give the insurance company just the cost of the protection. You don't give them anything extra to hold for you. Why, then, when you insure yourself against dying before you have had time to accumulate an estate, should you give the life insurance company something extra to put aside in a savings account for you? If you lack the will-power to save and need to have an insurance company take the money away from you, you should at least realize that you are paying a high price for your weakness.

We are agreed, then, that the cash value you get back from policies other than term insurance is merely a part of the extra premium that you need never have given them in the first place, and that the extra premium would work a whole lot more efficiently for you somewhere else. Incidentally, insurance men make much of the fact that term insurance is not "permanent" protection, that it can be carried only until age 65-70. Bear in mind that the whole purpose of insurance is to give you time to accumulate an estate. If you have lived to 65 and have been reasonably prudent, you will have accumulated the estate, and you need not pay the high premiums necessary to keep protection in force beyond that age.

2. What does an insurance company do with your money that makes insurance so "safe"? They invest it. Do they have some magic wand which they wave over their investments which makes them safer? I think not. Two of the country's

largest insurance companies loaned a Texas wild-cat oil promoter over 40 million dollars of policyholders' money. He hasn't even paid the interest, much less repaid the principal. It is now disclosed that two officers of one of the companies have been on the delinquent borrower's payroll at \$50,000 per year. Another insurance company put up the money to build a bridge over the Nebraska River. The bridge is there, but the river perversely flows elsewhere—and the bonds are in default. Who takes the loss? The policyholders. The list of defaulted bonds owned by life insurance companies is a long one. I am not decrying the investment judgment of insurance companies. I merely observe that investment is a difficult job for anyone, including insurance companies, and the men who manage their investments are ordinary human beings who are just as susceptible to error as anyone else.

American life insurance companies own hundreds of millions of dollars worth of common stocks, and they are buying more every day. A *New York Times* article of September 19, 1954, reported that the investment policies of the life insurance companies tend more and more to parallel those of the mutual funds. What makes General Electric stock safer when it is owned by an insurance company (which gets the profit and gives you a little bit of interest) than when it's owned by a mutual investment fund (which gives you the profit)? I suggest that the author of "The Great Fallacy" would have a hard time convincing Georgia's many stockholders of the Coca-Cola Company that they would be better off now if they had bought a 20-year endowment instead of Coca-Cola stock back in 1935. Yet a booklet currently being distributed by insurance men describes people who buy mutual funds as "lambs being enticed to the investment slaughter". How silly can they get?

Let us face the fact that unless you are a loan shark, you will never get anywhere by loaning your money at interest, even to an insurance company. The American people have made more money than any other people in the world and they have saved it. The savings banks, postal savings, building and loan associations and insurance companies are bulging with cash. Billions in war bonds are outstanding. Yet today we require a Social Security Act to take care of us when we are 65 years old. Why this curious economic paradox? If we made all that money and saved it, why do we need this dole in our old age? The answer lies in the miserably small return we got

on our money. We cannot in our working lifetime accumulate enough to let us sit back at age 65 with our financial independence and our self respect intact.

The great fortunes in this country were not built by loaning money at interest, even to insurance companies. These fortunes grew from an investment in the prosperity of American business and industry. More and more people realize this, and, in these years of change in many things, a great financial revolution is in progress. Those who regard this as a "Great Fallacy" will find themselves bucking an irresistible tide.

Beardsley Ruml, the distinguished former chairman of the board of the Federal Reserve Bank of New York, author of the pay-as-you-go tax plan and presently a trustee of the Committee for Economic Development, recently told an audience, "Insurance is not an efficient way to save except for those who find it difficult to save systematically in any other way. I favor placing the bulk of systematic savings in equity situations (common stocks). For most individuals . . . the diversified investment fund (mutual fund) is more suitable."

None of this takes into account the most deadly weakness of life insurance—its vulnerability to inflation. Insurance "guarantees" an income, but it gives no assurance of what that income will buy; one cannot eat those income dollars—one must exchange them for goods or services. In each of the past 15 years, the American dollar has lost five per cent of its then purchasing power. Thousands of old people have had to go back to work because the "guaranteed income" from their insurance is no longer sufficient to pay their living expenses. The insurance companies who once advertised a retirement income of \$100 per month now offer one of \$250 per month. The trusting souls who paid in their hard-earned 1920-40 dollars to get that \$100 income are now being paid off in what Al Smith once called "baloney dollars".

Many years ago, the Carnegie Foundation for the Advancement of Teaching created the Teachers Insurance and Annuity Association which was intended to function on a non-profit basis as an insurance company for educators. But in 1951 the TIAA reached this conclusion:

"Security in retirement poses a difficult problem when it means not only a sufficient annuity income in dollars, but also a reasonable income in purchasing power. Traditional methods of

saving have fallen short of the goal of providing suitable purchasing power income."

As a result, the College Retirement Equities Fund was organized in the summer of 1952. Its purpose—to give teachers a safe way to invest instead of having to depend upon such things as insurance policies. In its explanation to the teachers, the new fund reported:

"Business activity has its ups and downs—the investor in common stocks must expect them—but in the long run an accumulating share in the growth and earnings of the major American industries seems a good way to assure a healthy retirement income, much as industrial growth helps assure the economic well-being of the nation as a whole."

The faculties of more than 450 schools and colleges now participate in this new program which the Foundation's 1954 mid-year report called an unqualified success.

This economic trend is going to continue. Carol Shanks, president of the Prudential Insurance Company, has just said, "The greatest danger to the economy now by all odds is inflation". Are not those who now offer insurance as a "safe investment" and who talk of its "guaranteed income" making a mockery of "security"? America's security is only the sum total of the "security" of its citizens. If a great segment of the public is led to depend upon a form of "security" which is more apparent than real, we shall all suffer in the end.

3. We have already noted that the cost of selling an insurance policy is 15 per cent, according to the Institute of Life Insurance. The cost of gaining entrance to a mutual fund is only eight per cent. The relatively small cost of the continuing services of the professional managers—equal to about 10c per share per year in the case of a typical large fund whose shares sell for about \$24—is far less than the profit you will lose by letting an insurance company invest your money and keep the bulk of the return.

4. There is a great deal of misinformation being handed out on the subject of life insurance and taxes. Many people are led to believe that insurance is exempt from Federal Estate Tax at death. It is a cruel sales talk but a fairly safe one—the recipient of such "tax information" will not be around to confront his informant when the tax is collected.

As for income tax exemptions, the only thing which is not taxable is that which is not income.

FIGURE I

ENDOWMENT INSURANCE vs. MUTUAL FUND/TERM INSURANCE

ENDOWMENT INSURANCE

MUTUAL FUND AND TERM INSURANCE
MUTUAL FUND TERM INSURANCE

	Cumulative Premiums	Cash Value	Estate Value*	Cumulative Cash Payments	Cumulative Costs** Total	Liquidation Value on Dec. 31**	Cumulative Premiums	Face Value	Total Estate Value*
1939	\$ 1,500	\$ 628	\$23,267	\$ 1,350	\$ 1,375	\$ 1,365	\$ 180	\$20,000	\$21,365
1940	3,000	1,978	23,267	2,550	2,648	2,531	360	20,000	22,531
1941	4,500	3,350	23,267	3,750	4,011	3,497	540	20,000	23,479
1942	6,000	4,770	23,267	4,950	5,430	5,307	720	20,000	25,307
1943	7,500	6,212	23,267	6,150	6,911	7,793	900	20,000	27,793
1944	9,000	7,701	23,267	7,350	8,436	10,505	1,080	20,000	30,505
1945	10,500	9,237	23,267	8,550	9,972	14,182	1,260	20,000	34,182
1946	12,000	10,796	23,267	9,750	11,542	14,901	1,440	20,000	34,901
1947	13,500	12,424	23,267	10,950	13,247	15,470	1,620	20,000	35,470
1948	15,000	14,100	23,267	12,150	15,088	17,165	1,800	20,000	37,165
1949	16,500	15,821	23,267	13,350	17,157	22,228	1,980	20,000	42,228
1950	18,000	17,590	23,267	14,550	19,352	25,111	2,160	20,000	45,111
1951	19,500	19,428	23,267	15,750	21,654	29,359	2,340	20,000	49,359
1952	21,000	21,312	23,267	16,950	24,074	33,748	2,520	20,000	53,748
1953	22,500	23,267	23,267	18,150	26,615	35,521	2,700	20,000	55,521
1-1-54	\$22,500	\$23,267	\$23,267	\$18,150	\$26,615	\$35,521	\$2,700	————	\$35,521

*Estate values assuming investor dies on last day of year. Endowment costs \$1,500 per year (age 35); term costs \$15 per month.

**Based on an initial investment of \$250 followed by \$100 each month. Cumulative cost includes the regular cash investment plus the reinvested dividends from investment income, which totalled \$8,465. Year-end liquidation value includes shares acquired through reinvestment of \$5,618 of distributions from securities profits during the period.

The so-called "dividend" paid on your life insurance policy is not taxed because it is not a dividend at all; it is simply a refund of an overcharge. The retirement income paid by a life insurance policy is not all "income". It is partly your own principal being handed back to you, as your wife will sadly discover when you die leaving her tender memories and an insurance policy which says that since you had received 10 years income payments, there is nothing left for her. Naturally, you don't have to pay any tax when you spend your own money. If you have had the tax people come in and go over your books, I don't need to tell you that there is no such thing as a "free lunch". If it is income, you pay a tax on it. One of our clients even had to pay a tax on two baskets of grapefruit a patient sent him from her grove in Florida.

In conclusion, I should like to deal factually with the contention that taxes and investment risk make it not worthwhile to invest. The chart below compares the actual results of investment during the past 15 years in a life insurance endowment policy versus term-insurance-plus-a-mutual-fund. The costs of both types of policies are those of a representative stock insurance company offering "guaranteed cost" policies. For the fairest possible comparison, I have used the shares of the balanced mutual fund which recognized authori-

ties rate as the most conservative in the country. Its portfolio is balanced between bonds, preferred and common stocks and resembles somewhat that of the Rockefeller and Carnegie Foundations. Unlike all insurance companies, it has not a single defaulted bond in its portfolio. It does not loan money to Texas oil promoters. So far as I can learn, it is a legal investment for trust funds everywhere in the country; in many states, it is a legal investment for savings banks. The figures speak for themselves. (See Figure I.)

The author of "The Great Fallacy" illustrates his point with the story of an insurance policy into which approximately \$4,400 has been deposited annually for 28 years, a total of \$123,726. Thereafter, this produces a guaranteed annual income of \$11,793 after taxes.

The balanced mutual fund used in the above comparison of endowment insurance versus term insurance plus a separate investment has been in existence for 25 years. If \$4,400 had been invested in this fund each year since its inception one would have paid in a total of \$114,000. The liquidating value of the investment on June 30, 1954, would have been \$361,499. I estimate that in the case of a man in the 38 per cent tax bracket, filing a joint return with his wife, this would provide a net after-tax income of \$18,740, compared with the \$11,793 provided by the insur-

	Amount paid	Value after 28 years	Annual income (after taxes) at retirement	Amount left to his family at his death after 10 years
Endowment Policy	\$123,726	\$169,000	\$11,793	0
Mutual Fund	114,000	361,499 (after 25 yrs.)	18,740	\$361,499

FIGURE II

ance. And what a difference when he dies! Which do you choose? (See Figure II.)

Life insurance is a wonderful thing. There is no substitute for it—few of us own as much protection as we need. We owe a debt to the nation's insurance men who, with legendary persistence, have nagged us into doing the things we should do to protect our families. We can only hope

that the day may soon come when they will recover from the occupational disease from which so many of them appear to suffer, that curious form of blindness which makes them sincerely believe that life insurance is the be-all and end-all of everything and that nothing else is honest, reputable or worthwhile.

114 State Street

Korea--Bargain For Humanitarians

Korea is "the world's greatest bargain for investments in humanitarian projects," a medical consultant to the United Nations secretariat said recently.

Dr. Howard A. Rusk, New York University College of Medicine, said that Korea has "an extremely difficult problem" but is doing a big job with very little money.

Through emergency help, the United Nations Korean Civil Assistance Command and its Korean counterparts have "achieved one of the world's truly remarkable results in the control of epidemic diseases . . . in an unbelievably short time."

But Dr. Rusk said the rest of the situation in Korea could be understood by picturing any American city of 25,000 with one fourth of the homes destroyed and another fourth unroofed or damaged, sewers destroyed, 1,250 persons with tuberculosis, almost everyone chronically undernourished, scores blind or with leprosy—and only one poorly trained doctor.

The primary need is for trained personnel. Only 3,500 of the 6,800 medical practitioners have medical school training, and nearly half of the country's 5,000 doctors of medicine are in the army, leaving 2,500 to care for more than 20 million persons.

With about \$600,000 of voluntary contributions, the American-Korean Foundation has started the first school of public health in Korea, re-established nursing schools, and set up short

courses in tuberculosis control, midwifery, and nursing. A rehabilitation center for the physically handicapped and national programs for tuberculosis and leprosy control have been started.

This can be done only because of the tremendous buying power of a dollar in Korea, he said. A student can attend medical school for four years for \$1,200. For \$20 apiece, 2,000 American physicians bought goods for two suits and a raincoat each for the same number of Korean doctors.

Other voluntary contributions have been made: 70,000 textbooks have been contributed by American book publishers in answer to an appeal in the *Journal of the American Medical Association*, and the drug industry has sent more than \$2,250,000 in drugs and medicines through the American-Korean Foundation. One carload worth \$300,000 was sent by one company. A surgical appliance company contributed an entire carload of brace parts valued at \$60,000.

Dr. Rusk said that it is "not surprising" that health professions have responded enthusiastically.

"We in America have always been proud of the spirit of voluntary service shown by members of the health professions," he said. "We have untold confidence in our men and women in white, for they have long symbolized mercy and compassion. Today our health professions, by their voluntary aid to Korea, are once more demonstrating that this confidence is well merited."

Anaphylactoid Reaction with Death Following the Injection Treatment of Varicose Veins with Sodium Morrhuate

CALDER B. CLAY, M.D. and GORDON JACKSON, M.D., Macon, Ga.

ACCORDING TO Melkon and Schridell,² the treatment of varicose veins by the injection method started in Europe, being used in 1904 by Tavel and in 1912 by Linsen. Sodium morrhuate was first employed in the 1920's and soon received wide popularity. Shelly⁴ states that it is not surprising that sodium morrhuate should cause a variety of allergic reactions in that it is impossible to remove all of the nitrogenous materials contained in the cod liver oil. As early as 1932, Ritchie³ called attention to these reactions and described the following three types:

1) Erythematous or urticarial manifestations of the skin.

2) Gastrointestinal disturbances with abdominal pain and diarrhea appearing shortly after injection.

3) Collapse with cyanosis, pallor, low blood pressure and temporary loss of consciousness.

The third type described by Ritchie is undoubtedly a nitroid reaction and if sufficiently severe may cause death. Levi,¹ in 1938, called attention to the fact that deaths have followed the injection of sodium morrhuate. In 1939 Shelly⁴ emphasized that death occurs oftener than the literature would indicate. He stated that a physician from the medical examiner's office in New York City saw three such deaths none of which was reported in the medical literature. However, many severe anaphylactoid reactions without death have been reported. These reactions usually occur with the first or second injection following at an interval after a previous series of injections.

In the Report of the Council of Pharmacy and Chemistry appearing in the *JAMA* in 1942,⁵ 10 per cent sodium morrhuate was omitted from the N.N.R. Five severe reactions, two fatal, were reported. Both of these deaths were attributed to pulmonary embolism. Post mortem examinations were not done.

CASE REPORT

B. H., A 43 year old colored female, was seen in the surgery clinic of the Macon Hospital in November of 1953 com-

plaining of "leg ulcers." She had had varicose veins with stasis dermatitis and ulceration intermittantly for seven years.

Five months previously she had a bilateral stripping of the long saphenous systems under general anesthesia at the Macon Hospital. Her post operative course was uneventful. Following her discharge from the hospital she was seen at frequent intervals in the out-patient department. The ulcers were treated locally with Furacin® dressings and elastic support. After six weeks of this treatment the ulcers healed completely. Two and one half months later she returned with a recurrent ulceration which was attributed to a post phlebitic syndrome involving the deep veins of the leg. Treatment was resumed with Furacin and elastic support. Two weeks prior to her death it was noted that the entire left leg was covered with weeping eczematous lesions. This was thought to be an allergic reaction to Furacin. The Furacin was discontinued, zinc oxide ointment was applied locally, and the patient was given antihistamines.

On her last clinic visit the dermatitis had almost completely subsided. It was thought advisable to inject the small remaining varicosities with five per cent sodium morrhuate. Two injections of 0.2 cc. each were performed on the left leg and one injection of 0.2 cc. was performed on the right leg. When the patient attempted to sit down she had to be helped into the chair. On inquiry as to how she felt, she stated she felt weak and dizzy. She developed muscular twitchings of the left side and slumped to the left, falling out of the chair. She was placed on examining table and 0.5 cc. of 1/1000 aqueous adrenalin given intramuscularly. No blood pressure or pulse could be obtained and respirations were gasping and infrequent. Ten cc. of 20 per cent calcium gluconate was given intravenously followed by a drip of 1000 cc. five per cent Glucose in distilled water with four cc. of two tenths per cent Levophed. Resuscitation was begun with oxygen under positive pressure with an Emerson resuscitator. Some 30 minutes after the injection of the sodium morrhuate the patient was pronounced dead. Since this catastrophe occurred in the out patient department, facilities for cardiac massage, within reasonable length of time, were not available. Permission for autopsy was not granted.

Conclusion

A case is reported in which anaphylaxis and death followed the intravenous injection of a very small dose of sodium morrhuate.

654 First Street

REFERENCES

1. Levi, David: The Injection Treatment of Varicose Veins, in Rolleston, Humphry and Moncrieff, A. A.: Practical Procedures, London, Eyre and Spottiswoode, 1938.
2. Melkon, D. A. and Scheidell, D. K.: Allergic Manifestation After Injection Treatment of Varicose Veins, New England J. Med. 236:940-942 (June) 1947.
3. Ritchie, Alison: Treatment of Varicose Veins During Pregnancy, Abstr. Edinburgh M. J. 126:157-164 (Nov.) 1937.
4. Shelly, Harikd: Allergic Manifestations With Injection of Monoethorolamine Oleate, J.A.M.A. 112:1792-1794 (May 6) 1939.
5. Report of the Council of Pharmacy and Chemistry, J.A.M.A. 119:498-499 (June 6) 1942.

abstracts by georgia authors



Goldberg, Ira, 1415 Gwinnett St., Augusta, Ga. "Primary Adenocarcinoma of the Fallopian Tube," Am. J. Obst. and Gynec. 68:1169-1173 (Oct.) 1954.

While carcinoma of the Fallopian tube is the rarest of the pelvic neoplasms (approximately 533 cases being reported to date), it is also the most malignant. The diagnosis is very difficult to make preoperatively, this probably being one of the reasons for the poor prognosis. A triad of symptoms which may aid in the preoperative diagnosis are: (1) Irregular vaginal bleeding with an intermittent sudden release of fluid; (2) Low abdominal distress; (3) Palpable adnexal mass. A further diagnostic aid may be the vaginal smear.

The accepted treatment today in operative cases is total hysterectomy with bilateral salpingo-oophorectomy, although post-operative radiation is advocated by many. Radiation is also indicated for palliation for advanced cases and for recurrent cases.

Two cases are presented in this paper, both of which were diagnosed post-operatively. Total hysterectomy with bilateral salpingo-oophorectomy was done.

In conclusion, in order to make earlier diagnosis, one should keep in mind that surgical exploration is indicated in any unilateral mass in a menopausal or pre-menopausal woman that is associated with irregular vaginal bleeding and a negative curettage.

Hamm, William G.; Kanthak, F. F. and Yarn, C. P., 710 Peachtree St., N.E., Atlanta, Ga. "Elephantiasis of the Lower Extremity," Am. Surg. 20:1222-1226 (Nov.) 1954.

Elephantiasis is now recognized as being the late result of persistent lymphatic obstruction, usually with a secondary streptococcal infection, rather than being a sequela to tropical infection. It is characterized by marked thickening of the dermis, hyperkeratosis, dilatation of lymph capillaries and small lymph vessels, hypertrophy of sweat glands, disappearance of hair follicles, swollen bundles of collagen fibers and great quantities of fluid in the subcutaneous tissue, and replacement of fat tissue by fibrous tissue.

CASE REPORT

A 46 year old white man presented a left leg enormously swollen from the groin to the toes with an increase of approximately 140 pounds over his normal weight, all other physical findings being within normal limits. At the first operation to remove the involved tissue from the anterior surface of the thigh and leg, seven gallons of clear fluid were collected and the weight of tissue removed was 47 pounds. To remove all the involved tissue and resurface the entire leg and dorsum of the foot with skin grafts required nine operations, which were complicated by sudden, marked drops in blood pressure, a septic infarct in the left lung with pneumonitis and pleuritis, and the discovery of diabetes which had to be brought under control. When last seen he was in good condition and able to walk without difficulty.

Miller, James A., Jr., Ph.D., and Miller, Faith S., Ph.D., Emory University, Emory University, Ga. "Factors in Neonatal Resistance to Anoxia," Surg. 36:916-931 (Nov.) 1954.

Since the oxygen needs of all tissues vary with temperature changes, the rationale for the standard practice of warming asphyxiated babies was questioned and preliminary experiments performed in 1949. Neonatal guinea pigs were tested for the effects of variations of colonic temperatures upon resistance to asphyxia in 95% N₂ + 5% CO₂. Cooled animals recovered from asphyxia lethal to littermates 10°C, or more warmer. Cooling during asphyxiation increased survival time 14 per cent. Cooling before asphyxiation to colonic temperatures of 43.5° to 20°C. gave a linear increase in survival time of approximately 50 per cent 10°C. decrease in colonic temperature. Above this range animals died before experimentation whereas below some died from excessive hypothermia and others survived very much longer than expected. Rapid rewarming of cooled severely asphyxiated animals caused more rapid recovery of those which survived but did not increase the number of survivors. From a review of the literature on asphyxia and on hypothermia

and the experiments reported here the recommendation is made that hypothermia be tested as an adjunct to other resuscitative measures in asphyxia neonatorum in the human infant.

Olansky, Sidney, Wood, C. E. and Edmundson, W. E., Communicable Disease Center, Public Health Service, Chamblee, Georgia. "Intramuscular Chloramphenicol in Outpatient Treatment of Venereal Disease," AMA Arch. Dermat. and Syph. 70:625-630 (Nov.) 1954.

Outpatient treatment of venereal diseases with one or more intramuscular injections of chloramphenicol is described.

Twenty-three of 24 patients with granuloma inguinale were effectively treated with 12 to 16 gm. of chloramphenicol. Half of 36 patients with chancroid were cured with one four-gm. injection; additional injections were necessary to heal the remaining patients' lesions.

Seventeen of 18 patients with early lymphogranuloma venereum were cured, but with results considered inferior to those with chlortetracycline.

Chloramphenicol injections were effective in 50 per cent of 38 patients with nongonococcal urethritis. Oxytetracycline was superior.

In nongonococcal urethritis, 11-dehydro-17-hydroxycorticosterone acetate was ineffective.

No toxic or sensitivity effects were seen.

Victor, Irving, 228 East Huntingdon Street, Savannah, Ga. "Somatic Manifestations of Genital Tract Disease in the Male," Sou. Med. J. 47:1110-1114 (Nov.) 1954.

Referred pain from disease originating in the genital tract of the male may easily mask the primary site of disease. Insufficient knowledge as to the proper diagnosis often leads to erroneous misdiagnoses and oft-times needless surgery. A thorough understanding of the basic neuroanatomy concerned with the genital tract is necessary to understand these referred pain complexes. A thorough discussion of the underlying neuroanatomy is made, following which segmental distribution of the referred pain complexes is outlined. The necessity for thorough urological examination including an exhaustive history is oft-times necessary before discovering the primary pathology. A plea is made for a better understanding of these referred pain syndromes so that needless surgery will not be made.

Wagh, William H., Medical College of Georgia, Augusta, Ga. "Cortisone and The Treatment of Heat Stroke (Case Report)," Ann. Int. Med. 41:847-843 (Oct.) 1954.

In view of the antipyretic properties of cortisone and a thesis that cortisone may prevent the hyperthermia of hypothalamic injury, cortisone was administered to two patients with heat stroke to determine if cortisone would manifest an antipyretic effect in this disease. During the study, evaporative cooling of the patients was maintained. Cortisone administered orally in one patient and intravenously in another case appeared ineffective in reducing the hyperthermia and in relieving the anhidrosis of heat stroke.

Ween, H. S. and Florence, T. J., Grady Memorial Hospital, Atlanta, Ga. "The Diagnosis of Hydronephrosis by Percutaneous Renal Puncture," J. Urol. 72:589-595 (Oct.) 1954.

The radiologic diagnosis of hydronephrosis is usually adequately established by excretory or retrograde urography. In occasional cases, however, conventional radiographic procedures fail to yield satisfactory information. This may occur in the presence of urethral stricture or marked ureteral obstruction.

Under such circumstances, the diagnosis of hydronephrosis may be ascertained by direct renal puncture with injection of contrast medium into the dilated kidney pelvis or calyces.

Following a brief description of a simple method of renal puncture, the authors describe four cases in which renal puncture could be utilized to advantage. It is shown that renal puncture may at the same time serve to determine the presence and type of urinary tract infection.

The authors emphasize that this method should be applied only to selected cases and should not be a substitute for conventional urographic procedures.



doctor placement page

NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

AVAILABLE PHYSICIANS

MacKavanagh, James L., M.D., 160 Marion Avenue, Marrick, L. I., New York, age 44, married, Roman Catholic, graduate Georgetown University Medical School, 1934, presently in general practice, wishes to relocate, priority 3, interested in general practice in Georgia, size of community not too important, available within two or three months after location is selected.

Stark, C. V., M.D., Box 109, Arcadia, Fla., wants practice in Georgia during spring of the year only, as he spends winters in Florida, born November 25, 1878, widower, graduate Oploma Medical University, Tenn., 1900, specialty—general medicine, population 1,000 or more.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland. Age 39. Married; Roman Catholic. Graduate Georgetown University, 1948. Residency U. S. Naval Hospital, Bethesda, Maryland. Priority 5. Specialty—Internal Medicine. Desires community in Georgia of 20,000 to 30,000. Available June, 1955.

Upchurch, Kent P., 215 Pine Valley Road, Winston-Salem, N. C.; age 30; married; Protestant; graduate Bowman Gray School of Medicine, 1946; Board qualified in Ob and Gyn; interested in group practice or woman's clinic as an assistant or associate; available September 1, 1954.

Berry, Bradley D., M.D., Whitfield, Mississippi; graduate Jefferson Medical College, Philadelphia, Pennsylvania; completed internship; interested in general practice in Georgia.

Crupie, Joseph E., M.D., 347 Plant Street, Apt. 4-F, Tampa, Florida; age 30; married; graduate University of Tennessee School of Medicine; 1953; Priority IV; interested in general practice in Georgia; available 1st week in February 1955.

Stewart, Lena M., M.D., 250 N. Ottawa Street, Joliet, Illinois; age 65; single, Methodist; graduate Chicago College of Medicine and Surgery; 1917; residency—Deaconess Hospital; presently in practice, desires a milder climate; interested in general practice for girls school or student health; available November 1, 1954.

Watson, Alfred Lawrence, M.D., 1415 Titus Road, Memphis 11, Tennessee; age 29; married; Methodist; graduate Vanderbilt University School of Medicine, 1949; residency—2 years at Grady Hospital, Atlanta in internal medicine and at Kennedy Veterans Hospital, Tennessee; Priority IV; specialty internal medicine; prefers clinic, assistant or associate; available July 1, 1955.

Brooking, Donald G. W., M. D., 228 Finley Drive, Decatur, Alabama. Age 33; married; Protestant; graduate University of Minnesota, 1948; residency Brooke Army Hospital and Cornell University Medical College; passed examinations for certification by American Board of Dermatology and Syphilology; interested in Dermatology in a clinic, as assistant or associate or industrial; available immediately.

Calisch, Louis H., M.D., U. S. Naval Hospital, Charleston, S. C. Age 31; married; Jewish; graduate University of

Virginia Medical School, 1947; residency Johnston-Willis Hospital; finishing 27 months of active duty; specialty internal medicine; available January 1, 1955.

Collins, Douglas, M.D., 172 Riverside Park, Iowa City, Iowa. Age 33; married; Methodist; graduate University of Alabama School of Medicine, 1951; residency State University of Iowa Hospital; specialty Ob-Gyn; available July 1, 1955.

Gianoulis, James T., M.D., 611 West Grace Street, Richmond 20, Virginia. Age 38; married; graduate Medical College of Virginia, 1941; interested in general surgery and gynecology; Priority IV; six year surgical residency at Medical College of Virginia Hospital; looking for a permanent location with a future.

Gwinn, John L., M.D., 1309 Third Avenue, S.W., Rochester, Minnesota. Age 32. Married; Protestant; graduate University of Louisville, 1946; residency Mayo Clinic; finishing a fellowship in pediatrics; priority IV; specialty pediatrics; prefers practice in Georgia; available January 1955.

Hunter, I. H., M.D., 204 East Hill Avenue, Valdosta, Georgia; age 73; married; Missionary Baptist; graduate Grant University, 1903; interested in general practice; specialty pediatrics; prefers community of 1,000; will accept good position with clinic; available immediately; been in active practice for 50 years.

McConnell, Ben H., M.D., Box 664, Beltsville, Maryland. Seeking position as a student health physician. Age 36; married; Episcopal; graduate Georgetown University, 1950; interested in general practice as student health physician with any school, college or university; available at once.

McGarry, Paul A., M.D., Charity Hospital, New Orleans, Louisiana. Age 26. single; Roman Catholic; graduate Temple Medical School, Philadelphia, Pennsylvania 1954; presently interning; 2A Priority 3; interested in general practice in a rural area; available August 1955.

Scruggs, W. H., M.D., Bryson City, N. C. Age 65; limited general practice; 1 year in TB work, 3 years in general surgery; licensed in Georgia; married; Baptist; graduate University of Maryland, 1913; prefers small town with hospital. Available immediately.

Marder, Leon, M.D., 323 East Chestnut Street, Louisville 8, Kentucky. Age 32; married; Hebrew; graduate University of Oklahoma, 1949; residency St. John's, General and Michael Reese Hospitals; specialty internal medicine; wishes to associate or share office space with another physician or enter private practice in a community where vacancies exist; available July 1, 1955.

Peake, Charles O., M.D., 844½ Ninth Avenue, S.E., Rochester, Minnesota. Age 27; married; Methodist; graduate University of Pennsylvania, 1951; residency Mayo Foundation; Priority IV; specialty Ob-Gyn; interested in locating in Georgia particularly Atlanta; available July 1, 1955.

Sharp, Thomas B., Jr., M.D., 1530 Shoup Court, Decatur, Georgia; age 28; married; Protestant; graduate Emory University, 1950; residency Lawson VA Hospital and Grady Memorial Hospital; military requirements fulfilled; specialty internal medicine; clinic preferably; available July 1, 1955.

Augustine, Robert W., 2825 Old Selma Road, Montgomery 8, Alabama—age 42; married; Episcopal; graduate University of Chicago, 1937; residency Charity Hospital; Duke Hospital; American Board of Orthopedic Surgery; specialty Orthopedics; prefers practice in South; available December 1954.

German, Walter A., Jr., 1534 Shoup Court, Apartment No. 2, Decatur, Georgia—age 30; married; Methodist; graduate Washington University School of Medicine, 1951; residency Grady Memorial Hospital; specialty Ob-Gyn; associate; available July 1, 1955.

Jerius, Diab H., 18218 Appline Street, Detroit, Michigan—age 51; single; Protestant; graduate Lausanne University, Switzerland, 1935; residency Sinai Hospital, Detroit; interested in general practice in Georgia as an associate, available immediately.

Shannon, Lloyd W., 1234 Henleaze Avenue, Moose Jan, Saskatchewan, Canada—age 31; Canadian; married; Presbyterian; graduate University of Manitoba, 1947; residency Baltimore Aby Hospital (3 years) and University of Colorado Surgeon Res. (2 years); presently in practice, wishes to relocate because medicine is becoming greatly socialized in Saskatchewan; specialty general surgery; industrial, assistant or associate, would consider clinic; available February or March 1955.

Smith, Claude K., Jr., Delcambre, Louisiana—age 27; married; Methodist; graduate Louisiana State University School of Medicine, 1952; interested in industrial practice in South; just discharged after total of eight years in Navy; available January 15, 1955.

Todd, John Wesley, T-8616 Apartment C, Fort Lee, Virginia—age 33; married; Presbyterian; graduate Medical College of Virginia, 1947; residency Mayo Foundation; desires a job for a six month period January-July, prior to continuing residency; priority IV; specialty general surgery; assistant; prefers South or midwest to practice.

Young, E. Reynolds, Philadelphia General Hospital, 34th Street and Curie Avenue, Philadelphia, Pennsylvania — graduate Vanderbilt University School of Medicine, 1954; internship Philadelphia General Hospital will be completed in July 1955; interested in general practice; prefer to assist or associate with practitioner already established.

AVAILABLE LOCATIONS

Meigs, Georgia - Thomas County - one doctor's clinic available, with ample space for a two doctor set-up; one aged doctor; hospital facilities nearby; good schools; paved highways; contact: Mr. O. H. Lewis, Meigs Clinic, Inc., Meigs, Georgia.

Pearson, Georgia - Atkinson County - will furnish house and equip clinic; new Hill-Burton Hospital at Douglas guarantees staff privileges to GP; office will be rent free for six months; contact Mr. Barney Kraft, Pearson, Georgia.

Villa Rica, Georgia (Carroll County) New 24 bed HB hospital to be built soon.

Now have seven bed hospital. Office available for lease, reasonable. Housing available at reasonable cost. 12 grade accredited school. (Pop. 3,200). Contact: Mr. Edgar P. Candler, Villa Rica, Georgia.

Jeffersonville, Georgia—Twiggs County—Only doctor in county is in his 70's and has been doing limited practice. Contact Mr. H. C. Swearingen, Jeffersonville, Georgia. (Population 1,000).

Woodbine, Georgia—Camden County—Small fully equipped and stocked office and clinic immediately available; ample office space, delivery room, laboratory (including x-ray), nursery, wards and private rooms; can be used as office, clinic or small hospital; 5 room wooden dwelling adjoins to hospital, available at \$35.00 per month or other houses for rent or sale; one other doctor in Woodbine. Doctor is needed now. Contact: Dr. Sam C. Atkinson, Waverly, Georgia. (Population 1,000).

Roberta, Georgia—Crawford County—No physician in area, county maintains a large home with most reasonable rental available for resident doctor. Plans for clinic nearing completion, immediate use of rooms in present clinic building, also

three rooms over post office ready for use, year's rent free. Excellent opportunity for qualified physician looking for general practice. Contact Mr. J. Welborn Johnson, P. O. Box 143, Roberta, Georgia.

Arlington, Georgia—Calhoun County—In need of a doctor-surgeon for practice in new excellently equipped 161 bed hospital located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia. (Population 1,382).

Attapulugus, Georgia—Decatur County—Present doctor unable to practice on full scale; has clinic with waiting rooms for white and colored patients, x-ray, cardiogram, metabolism, pneumothorax, violet ray and laboratory equipment. Town is centrally located with access to hospitals. Present doctor will reserve working space in the clinic, will sell outright or lease the clinic at very nominal figure. Contact: Dr. Carl B. Welch, Attapulugus, Georgia. (Population 800).

Bremen, Georgia—Haralson County—Need an associate in field of obstetrics and gynecology. Completing a modern office building to house the group and about October 1st new 29 bed hospital

should be in operation. Group consists of three physicians—2 in surgery and 1 in medicine and anesthesia. Would have all the work he could handle in ob and gyn. Contact: Dr. J. H. Pritchett, Jr., Bremen Hospital, Bremen, Georgia. (Population 3,500).

Edison, Georgia (Calhoun County)—population 1,245; two physicians in area; Hill-Burton Hospital (1 mi.); one clinic (local) 10 beds; x-ray, lab equipment; operating room with instruments; rental \$75.00 per month (maximum \$100.00 per month); two excellent drug stores; housing available for rent at \$30.00-\$40.00; good elementary and high school; five churches; great need for a physician in this community; contact: Dr. J. S. Beard, Edison, Georgia.

Athens, Georgia—on January 1, 1955 will have opening for full time physician as Assistant Director of the Department of Student Health; the University has 5,200 students and the position is a very active one; salary will be approximately \$7,000-\$7,200; applicant must be of excellent character, in good physical condition and eligible for a Georgia license; prefer an applicant between ages of 40-50; either male or female; contact J. H. Robbins, M.D., Department of Student Health, University of Georgia, Athens, Georgia.

Medical Courses Via Television

Physicians from all over Georgia will gather in Atlanta Thursday, February 24 at 6 p.m. at the Biltmore Hotel, to watch the largest closed-circuit television program ever staged.

The program, jointly sponsored by the American Academy of General Practice, Kansas City, Missouri, and Wyeth Laboratories, Philadelphia, Pennsylvania, will feature six internationally known medical authorities who will discuss "The Management of Streptococcal Infection and its Complications."

The Georgia Academy of General Practice will act as host at the Atlanta showing. The telecast will be viewed in 56 other cities throughout the U. S. In Atlanta, the program will be held in conjunction with the Southeastern Surgical Congress and The Atlanta Graduate Medical Assembly which will be meeting at the Biltmore February 21, 22, 23 and 24.

Speakers on the hour long program include Dr. John D. Keith, Associate Professor of Pediatrics at the University of Toronto and Physician-In-Charge of the Cardiac Clinic and Service of Toronto Sick Children's Hospital; Dr. Burtis B. Brese, Assistant Professor of Pediatrics at the University of Rochester; Dr. Lowell A. Rantz, Associate Professor of Medicine at Stanford University School of Medicine; Dr. Charles H. Rammelkamp, Jr., Professor of Medicine at Western Reserve

University and Dr. Gene H. Stollerman, Director of Irvington House, Irvington-on-Hudson.

What part television can play in future postgraduate medical education will be one of the featured attractions of the 51st annual Congress on Medical Education and Licensure to be held February 5-8 at the Palmer House, Chicago. The meeting will be sponsored by the AMA's Council on Medical Education and Hospitals in cooperation with the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties.

The first of a series of annual work-shop conferences in the field of postgraduate medical education will be devoted to the potential use of television during the all-day session February 5. Open meetings of the Advisory Board and the Federation will be held February 6.

Highlighting the place of legal and forensic medicine in undergraduate medical education and the future status of the internship in the medical education program will be discussed during the AMA Council's program February 7. The February 8 sessions will be conducted by the Federation.

More than 500 medical educators, officers and members of state licensing boards and others interested in postgraduate medical education are expected to attend the four-day conference.

Maternal and Infant Welfare Committee

Savannah, October 2, 1954

A luncheon meeting of the Maternal and Infant Welfare Committee and Sub-committee was held October 2, 1954, at the Oglethorpe Hotel in Savannah.

Those present were Peter Hydrick, Charles Mulherin, Hugh Bickerstaff and Helen Bellhouse. Doctors Alexander, Morrison, McPherson and Walker sent regrets. Dr. Mixon was unable to be present. Dr. Demmons of Savannah sat in on the meeting.

Known Sub-committee Activities—From J. L. Walker's District (9th) there was reported interested discussion and many questions based on the large maps he has prepared showing 1952 and 1953 statistics. Dr. Kelly had made a report to his district. No other reports were made.

Maternal death queries are being returned quite promptly. They are to be summarized and reviewed.

Date for conference of the committee for final review and preparation of follow-up letters was not set.

Livebirth Certificates—It was suggested after discussion that the State Health Department be requested to add two items to the livebirth certificates:

(1) Prenatal care qualified "adequate," "inadequate" or "none". This would, it was thought, give an index of public education and awareness of its value. Definitions of "adequate" can be made available.

(2) Scopolamine and hyoscine.

Fetal Death Certificates—Discussion revealed different patterns of reaction varying from rejection to all our efforts to complete the fetal death certificates. The committee was discouraged. It was unfortunate that the secretary failed to report that a study is already under way of the first six months period of operation. This may be helpful, especially if it is made available in the near future.

Meetings—There will be at least one more meeting before the annual session of the Medical Association when the chairman gives a summary report.

Rural Health Committee

Macon, November 14, 1954

AT A MEETING of the MAG Rural Health Committee held November 14, 1954, Dempsey Hotel, Macon, at 11 a.m. the following committee members were present: Charles T. Brown, Jr., Guyton, 1st District; W. P. Stoner, Sylvester, 2nd District; Maurice F. Arnold, Jr., Hawkinsville, 3rd District; T. A. Sappington, LaGrange, 4th District; Clyde A. Wilson, Jr., Brunswick, 8th District; Joe J. Arrendale, Cornelia, 9th District; Hubert Milford, Hartwell, 10th District; T. F. Sellers, Atlanta, Ex-Officio; and George T. Nicholson, Cornelia, Chairman.

Also in attendance were: W. A. Dodd, Wrightsville, 6th District Alternate, and Tully T. Blalock, President-Elect of the Better Health Council of Georgia, representing Mrs. Bruce Schaefer, Better Health Council president; and Mr. Milton D. Krueger, MAG Executive Secretary.

The meeting was called to order by Chairman Nicholson who referred to the MAG Constitution and By-Laws Chapter 9, Section 2, (I) concerning the purpose and duties of the Rural Health Committee. Dr. Nicholson clarified the concept of "medical service" to allow it to include "health of the public" rather than merely medical care.

Dr. Nicholson then discussed proposed functions of the Committee, its duties, privileges and responsibilities.

Mr. Milton D. Krueger presented a brief resume of the past Rural Health Committee activity and commented on Committee organization.

Dr. Sellers graphically described the role of the State Department of Public Health in the rural health field. He discussed those department divisions most concerned with rural health and assured Chairman Nicholson of continued cooperation.

Dr. Blalock explained the purpose and the functions of the Better Health Council of Georgia and discussed its present status. Dr. Blalock also assured the committee of continued cooperation and aid in the MAG Physicians Placement program as operated by the Rural Health Committee.

Chairman Nicholson then called for comment from each Committee member as to their ideas for committee projects. Remarks from committeemen were as follows:

Dr. Brown felt the committee should narrow its present objectives and concentrate on the few projects selected by the committee. He emphasized the need of facilities for attracting physicians to rural areas.

Dr. Wilson commented on the need for better distribution of physicians to include rural areas. He also expressed the importance of educating the public to help themselves in improving medical and health care in their areas.

Dr. Dodd emphasized the importance of physicians placement and what it meant to rural people. He stated that emergency care and night calls must be better handled. He cited the great need of small clinics when the county couldn't support a hospital.

Dr. Stoner emphasized the need of a safety program for home and farm accidents. He was also quite concerned with pre-school and school child immunization programs. Dr. Stoner said that the problem of alcoholism and mild mental cases are a rural problem. He stressed the importance of the state and county medical auxiliaries as an aid to the committee.

Dr. Arrendale suggested that the program of the committee be carried to the individual physicians at their county medical society meetings. He recommended that members of the Rural Health Committee be responsible for attending each county medical society meeting in their districts and educating the physicians to committee policies and projects. He further proposed the societies set aside a whole meeting program for this purpose. Dr. Arrendale cited the need for more small centers where nursing education could be gained to effect better nurses care in rural areas.

Dr. Arnold expressed his concern about immunization and recommended that a statewide standard be proposed for immunization requirements and procedure. He also emphasized the need for more effective physician placement. Dr. Arnold questioned the committee's ability to improve the physician distribution in the State.

Dr. Sappington explained his plan for the reorganization of the MAG Public Health Committee and its effect on the Rural Health Committee. Committee members heartily endorsed Dr. Sappington's plan. Dr. Sappington then stated that perhaps committee work could best be handled on a regional basis. He questioned the response gained from a county medical society visitation plan to disseminate committee plans and projects. He suggested that the Association, rather

than the Rural Health Committee, enlist the county medical societies' cooperation in having a rural health program at one of their regular meetings. He stated the need of a clear, uniform program to be worked out by the committee and effected throughout the rural area. Dr. Sappington also favored a more active preceptorship program and better cooperation between the general practitioner and the medical student and young physician. He stated the need to "sell" the young doctor on the satisfaction of a "Country Practice." He asked the committee to investigate all medical scholarship grants and disseminate this information. And he spoke of the need for smaller, better distributed schools of nursing education over the state.

Dr. Milford explained in detail the processes employed by the State Medical Education Board in granting scholarships as instituted under Georgia law.

Chairman Nicholson then discussed the following: (1) County Medical Society Visitation Program; (2) Selection and Solidification of Rural Health Committee Policies and Projects; (3) Education of MAG Physicians on Rural Health Committee Projects; (4) Physician Placement; effecting better distribution and use of the Better Health Council of Georgia in screening locations seeking physicians.

As summarized by Chairman Nicholson, the following projects were discussed by committee-men:

- (1) Need for better distribution of physicians and more physicians.
- (2) Encouragement of the provision of better facilities in rural areas to attract physicians.
- (3) Need for educating physicians on rural health needs and then educating rural public on health needs.
- (4) Need for accident prevention work in farm and home.
- (5) Need for standard immunization throughout state.
- (6) Need for better care for alcoholism and mental health.
- (7) County medical society visitation program for physician education and cooperation in rural health.
- (8) Fostering para-medical recruitment.
- (9) Statewide rural health conferences.

General discussion ensued, and it was decided that the policies and projects of the committee should be further considered by a "steering com-

mittee" to narrow down the primary objectives of the committee. The "steering committee" was requested to screen the many suggestions of the committeemen and plan the committee program subject to the approval of the full committee.

Appointed to serve on the "steering committee" were: George T. Nicholson, T. F. Sellers, Maurice F. Arnold and W. P. Stoner.

Dr. Nicholson then assigned committeemen projects to investigate for report back to the "steering committee" as follows:

W. P. Stoner, accident prevention information; Maurice F. Arnold, immunization information; Joe J. Arrendale, county medical society visitation plans; Charles T. Brown, physician placement information; T. A. Sappington, liaison with MAG Public Health Committee and other MAG committees; Clyde A. Wilson, Jr., mental health information, and Hubert Milford, educational funds available for prospective physicians.

Chairman Nicholson then requested each member of the committee to select an alternate from his district to attend committee meetings in the absence of members. He also requested that each committee member forward the information from the material assigned to the "steering committee" as soon as possible.

The meeting adjourned at 3:45 p. m.

Honorary Advisory Board

Macon, December 11, 1954

The meeting was called to order by Chairman Enoch Callaway at 7:30 p.m. Members of the Honorary Advisory Board present were: M. M. Head, A. M. Phillips, Ralph H. Chaney, W.F. Reavis and W. A. Selman.

Chairman Callaway appointed A. M. Phillips secretary for this meeting of the Board.

The minutes of the Honorary Advisory Board meeting held in Macon, May 2, 1954, were approved and adopted as published in the June 1954 Proceedings Issue of the *Journal of the Medical Association of Georgia*.

The next item of business discussed was the proposed operational policies for the Eugene Talmadge Memorial Hospital. The projected plans and recommendations were discussed paragraph by paragraph as presented to the Board. Discussion and action ensued as follows:

It was moved, seconded and approved that

Paragraph No. 1 be received as information.

Paragraph No. 2 was discussed at length, and it was moved and seconded that Paragraph No. 2 be approved. This motion was adopted.

Paragraph No. 3 was read, and a motion was made that it be adopted. The motion was duly seconded and approved.

Paragraph No. 4 was read, and it was decided to defer action on Paragraph No. 4 until Paragraph No. 5 and Paragraph No. 6 were fully discussed.

Paragraph No. 5 and No. 6 were read and discussed freely, and it was finally decided and so moved that the Honorary Advisory Board of the Medical Association of Georgia is in sympathy with the aims and purposes as outlined by the recommendations offered by the Joint Policy Committee composed of members from the Board of Regents, the State Board of Health and the Medical Association of Georgia; however, due to the fact that certain matters in the recommendations have not been clarified by the American Medical Association as to their ethical status, it is recommended by the Honorary Advisory Board that action be withheld until these matters can be acted upon by the AMA at its next regular meeting. The motion was duly seconded and carried.

The next item of business concerned a discussion of formulation of Association policy in regard to the question of whether or not it is ethical for members to practice in association with cultists. This matter was discussed at length, and it was recommended and so moved that, until further information and clarification of the policy of the American Medical Association regarding these matters is made, no action be taken by the MAG Professional Conduct Committee on this matter at the present time and that this information be transmitted to Council and the MAG Professional Conduct Committee. This motion was adopted.

The next item of business was a discussion of the structure and liaison with the State Medical Examining Board. It was made known and so moved that the relation between the Medical Association of Georgia and the State Medical Examining Board has improved, and it is hoped that the Medical Association of Georgia will be given more voice in the selection of the members of the State Medical Examining Board in the future than has been customary in the past. This was duly seconded and adopted.

Old business was discussed but no action taken.

Under the heading of New Business it was recommended that the Honorary Advisory Board of the Medical Association of Georgia hold its regular annual meeting on the evening preceeding the first House of Delegates meeting, the time and place of said meeting being left to the discretion of the Chairman of the Board. Also recommended was that so far as possible all matters to be considered by the Board shall be presented to each Board member at least two weeks prior to the Board meeting. This was presented in the form of a motion and was duly seconded and adopted.

A motion was then made and carried to adjourn.

Council of the MAG

Macon, December 11, 1954

The recessed regular fall meeting of the Council of the MAG held November 4, 1954, in Atlanta, was recalled to order at 8 p.m. December 11, 1954, at the residence of Milford B. Hatcher, 1290 Jackson Springs Road, Macon, Georgia, by Vice-Chairman W. G. Elliott, Cuthbert, in the absence of Chairman H. L. Cheves, Union Point.

Present, in addition to Dr. Elliott, were the following: Councilors, J. W. Chambers, LaGrange; W. S. Dorough, Atlanta; Neal Yeomans, Waycross; Lee Howard, Savannah; George Dillinger, Thomasville; D. Lloyd Wood, Dalton; Vice-Councilors, Ralph Fowler, Marietta; C. S. Pittman, Tifton; H. G. Weaver, Macon; J. G. McDaniel, Atlanta; Charles Andrews, Canton; Officers, Peter B. Wright, Augusta; Willard R. Golsan, Macon; Milford B. Hatcher, Macon; David Henry Poer, Atlanta; H. Dawson Allen, Milledgeville; William P. Harbin, Rome; AMA Delegates, C. H. Richardson, Macon, and Eustace Allen, Atlanta; AMA Alternate Delegate Henry Tift, Macon; and Mr. John F. Kiser. Dr. Andrews, Vice-Councilor, from the 9th District acted as Councilor in the absence of W. Bruce Schaefer.

The invocation was given by Milford B. Hatcher.

The minutes of the November 4 section of the meeting were presented and approved (see *JMAG*—December 1954).

The next item of business was the report of the Auditing and Appropriations Committee by J. W. Chambers. (See page 33.) Dr. Chambers presented the tentative budget for 1955, and discussion followed concerning three items in the budget: (1) donations to the Better Health Council, (2) the Woman's Auxiliary and (3) the Crawford W. Long Memorial.

Dr. Dougherty moved, seconded by Dr. Yeomans:

"That the donation to the Better Health Council be made this year on a contingent basis and that during the year Council study the question of whether or not the donation should be continued in 1956."

Dr. Poer moved that an amendment to the motion be added as follows:

"That a special Committee of Council be appointed to study the problem in regard to whether or not the donation to the Better Health Council should be continued in 1956."

The motion with the amendment carried unanimously.

The next item of business was the report of the AMA Clinical meeting at Miami, November 28-December 2 presented by Charles H. Richardson, Delegate.

Dr. Richardson's report emphasized two items as follows:

"Osteopathy—The AMA House concurred in the following supplementary report of the Board of Trustees on the osteopathic situation: 'Contingent on the receipt of the report from the committee to Study the Relations between Osteopathy and Medicine of its 'on campus' observations of osteopathic schools, the AMA House of Delegates in June, 1954, agreed to hold in abeyance any action on this important subject until this meeting.'

The AMA committee, after meetings and extensive negotiations with the American Osteopathic Association, has now made final arrangements for visiting five of the six schools of osteopathy, and these plans have been approved by the Board of Trustees.

"It is the recommendation of the AMA Board, therefore, that consideration of this matter be held in abeyance by the House of Delegates until the June, 1955, meeting, at which time the committee expects to have a complete report of its findings concerning the nature, scope and quality of education in schools of osteopathy.

"State Subsidized Medicine—Most controversial issue at the Miami meeting was a resolution on 'policy on Medical Practice by Tax Supported Medical Schools,' introduced by the Mississippi State Medical Association. This resolution provided that:

"The American Medical Association reaffirm its unalterable opposition to socialized and state subsidized medicine regardless of the form which it may assume, and

"The House of Delegates of the American Medical Association is of the opinion that these principles should be considered by constituent and component medical societies together with all other facts pertinent to the local situation in all controversies arising in the employment of medical faculty by state (tax) supported medical schools and be fully considered in effecting action within the framework of this policy."

"The AMA reference committee on Medical Education and Hospitals agreed with that portion of the resolution regarding 'unalterable opposition to socialized medicine' but recommended that the resolution be referred, without approval or disapproval at this time to the Council on Medical Service which currently is studying the various aspects of

TENTATIVE BUDGET FOR 1955

	1954 BUDGET	Income and Disbursements Dec. 1, 1954	1955 Tentative Budget
INCOME			
Income from Dues (1900 Active Members)	\$47,500.00	\$54,340.00	\$52,500.00
Journal Advertising	18,500.00	19,488.01	19,000.00
Fees Exhibitors Annual Session	5,500.00	7,350.00	6,500.00
Interest and AMA Service	2,000.00	1,773.12	1,700.00
	<u>\$73,500.00</u>	<u>\$82,951.13</u>	<u>\$79,700.00</u>
DISBURSEMENTS			
1. SALARIES	\$22,200.00	\$23,225.00	\$25,600.00
2. FIXED ALLOTMENTS			
Pension Payments	\$ 1,800.00	\$ 1,800.00	\$ 2,400.00
Honorarium—President	1,000.00	1,000.00	1,000.00
Attorneys Retainer Fee	1,200.00	1,100.00	1,200.00
Annual Audit	600.00	575.00	400.00
Cont. Fulton Co. Med. Soc.	1,500.00	1,200.00	1,500.00
Insurance and Bonds personnel	200.00	113.15	200.00
Woman's Auxiliary	850.00	1,300.00	1,300.00
Better Health Council	1,200.00	1,200.00	1,200.00
	<u>\$ 8,350.00</u>	<u>\$ 8,288.15</u>	<u>\$ 9,200.00</u>
3. JOURNAL PUBLICATION			
Engraving and Cuts	\$ 600.00	\$ 752.26	\$ 800.00
Editorial Assistance	100.00	97.07	100.00
Stationery	300.00	58.89	350.00
Postage	500.00	545.00	500.00
Clipping Service	200.00	163.85	250.00
Addressograph and Supplies	150.00	151.28	200.00
Copyright	50.00	48.00	50.00
Printing	18,750.00	19,122.47	20,000.00
	<u>\$20,650.00</u>	<u>\$20,938.82</u>	<u>\$22,250.00</u>
4. HEADQUARTERS EXPENSE			
Travel	\$ 2,600.00	\$ 3,463.02	\$ 4,000.00
Meetings (Council Cont.)	500.00	222.79	500.00
Stationery and Printing	2,000.00	941.97	1,000.00
Postage	800.00	610.91	800.00
*Telephone and Telegraph	1,200.00	1,374.15	1,600.00
Depreciation	500.00	400.00	500.00
Office Supplies and Expense	475.00	538.33	600.00
Dues and Subscriptions	250.00	203.61	200.00
Janitor Service	260.00	260.00	300.00
Payroll Tax	200.00	234.80	250.00
Sundry	300.00	452.15	300.00
	<u>\$ 9,085.00</u>	<u>\$ 8,701.73</u>	<u>\$10,050.00</u>
*Annual Session			\$ 200.00
Committees			\$ 200.00
Headquarters			\$ 1,200.00
5. ANNUAL MEETING			
Expense	\$ 6,000.00	\$ 7,123.18	\$ 6,500.00
6. COMMITTEE EXPENSE			
1. Rural Health	\$ 200.00	\$ 382.29	\$ 350.00
2. Medical Defense	600.00	96.27	200.00
3. Legislation	500.00	224.86	500.00
4. Maternal Welfare	150.00	126.68	150.00
5. Industrial Health	100.00	97.00	100.00
6. Public Relations	1,000.00	400.00	1,000.00
7. Insurance and Economics	1,000.00	353.10	600.00
8. Committee on Awards	200.00	99.72	150.00
9. A.M.E.F.	250.00	10.92	150.00
10. Veterans Affairs	200.00	36.65	100.00
11. Hospitals	100.00	32.80	100.00
12. History and Vital Statistics		57.79	300.00
13. Med. Civil Preparedness			50.00
14. Blood Banks			50.00
	<u>\$ 4,300.00</u>	<u>\$ 1,918.08</u>	<u>\$ 3,800.00</u>
7. NEW EQUIPMENT			
Machines	\$ 175.00	\$ 49.87	
Filing Cabinets	50.00	50.00	
Desk	125.00	125.00	
	<u>\$ 350.00</u>	<u>\$ 224.87</u>	
Total Disbursements	\$70,935.00	\$70,419.83	\$77,400.00
Contingent Fund	\$ 2,565.00		\$ 2,300.00
Bank Balance—December 1, 1954	\$22,959.55		
Including Income for 1955 Exhibitors	\$ 3,675.00		

this subject. The AMA House adopted the reference committee's recommendation."

Eustace Allen also commented on these two actions of the AMA House of Delegates.

Dr. Richardson stated he would like to read into the minutes a report of the high excellence of a talk given by Mr. Milton Krueger, Executive Secretary, during the AMA Public Relations Institute. Dr. Richardson said that Mr. Krueger made this talk on three minutes notice and that it was extremely well received.

The Delegates were commended by Council for their fine work in attendance at the AMA meeting.

The next item of business was the report of the Council Committee on Minimum Standards for county medical societies, presented by Dr. Hatcher.

The recommendations of this Committee which were approved by Council and referred to the Committee on Constitution and By-Laws were as follows:

"That (1) each county society meet a minimum of four times a year, elect officers and delegates annually and report these officers to the headquarters office; (2) each county society have a constitution and by-laws; (3) each county society have a Board of Censors and/or a grievance committee; (4) each county society secretary keep the minutes of each meeting in a permanent record book that will be available at all times; (5) each county society, at its minimum four meetings annually, have planned scientific programs." On motion (Eustace Allen-Dillinger) the report of the committee was adopted.

The next item of business was the final discussion on the proposed policies for the operation of the Eugene Talmadge Memorial Hospital. After considerable discussion by Drs. Dawson Allen, Poer, Howard, Eustace Allen, Dougherty, Fowler and Richardson, Dr. Wright clarified the background development of the plans for the hospital during the past several years. He advised that the Association take an advisory position, and representatives of the Association should, in the future, confer with Drs. Pund and Payne and the Board of Regents.

Following more discussion, it was moved and seconded (Eustace Allen-Poer) that a special committee be appointed consisting of the immediate past-president, the president, the president-elect and two members of Council to be appointed by the Chairman, and that this committee draw up a clarification of the proposed policies and a resolution, both to be presented to the House of Delegates on Sunday.

There being no further business the Council recessed.

December 12, 1954

The meeting was recalled to order at 9 a.m., Sunday, December 12, 1954, in the Mirror Room of the Dempsey Hotel by Vice-Chairman W. G. Elliott, Cuthbert.

Those present who were not in attendance Saturday night were Councilor W. Bruce Schaefer and guests Charles S. Jones, Insurance Board member, Ralph Chaney, Past President, and Enoch Callaway, Chairman of the Honorary Advisory Board. Absent were D. Lloyd Wood and H. L. Cheves.

The invocation was read by W. G. Elliott.

The report of the Honorary Advisory Board, for information only, was presented by Chairman Callaway. The report as follows:

"The meeting was called to order by Chairman Enoch Callaway at 7:30 p.m. Members of the Honorary Advisory Board present were: M. M. Head, Zebulon; A. M. Phillips, Macon; Ralph H. Chaney, Augusta; W. F. Reavis, Waycross, and W. A. Selman, Atlanta. Chairman Callaway appointed A. M. Phillips secretary for this meeting of the Board. The minutes of the Honorary Advisory Board meeting held in Macon, May 2, 1952, were approved and adopted as published in the June 1954 proceedings issue of the Journal of the Medical Association of Georgia.

"The next item of business was the proposed operational policies for the Eugene Talmadge Memorial Hospital. (See House of Delegates Proceedings, December 12, 1954, for list of proposed policies for operation of the Eugene Talmadge Memorial Hospital). The projected plans and recommendations were discussed paragraph by paragraph as presented to the Board. Discussion and action ensued as follows:

"It was moved, seconded and approved that Paragraph No. 1 be received as information.

"Paragraph No. 2 was discussed at length, and it was moved and seconded that Paragraph No. 2 be approved. This motion was adopted.

"Paragraph No. 3 was read and a motion was made that it be adopted. The motion was duly seconded and approved.

"Paragraph No. 4 was read, and it was decided to defer action on Paragraph No. 4 until Paragraph No. 5 and Paragraph No. 6 were fully discussed.

"Paragraph No. 5 and No. 6 were read and discussed freely, and it was finally decided and so moved:

"That the Honorary Advisory Board of the Medical Association of Georgia is in sympathy with the aims and purposes as outlined by the recommendations offered by the Joint Policy Committee composed of members from the Board of Regents, the State Board of Health and the Medical Association of Georgia; however, due to the fact that certain matters in the recommendations have not been clarified by the American Medical Association as to their ethical status, it is recommended by the Honorary Advisory Board that action be withheld until these matters can be acted upon by the AMA at its next regular meeting." The motion was adopted by the Board.

"The next item of business was a discussion of the structure and liaison with the State Medical Examining Board. It was made known and so moved:

"That the relation between the Medical Association of Georgia and the State Medical Examining Board has improved, and it is hoped that the Medical Association of Georgia will be given more voice in the selection of the members of the State Medical Examining Board in the future than has been customary in the past." This was duly seconded and adopted by the Board.

"Old business was discussed but no action taken.

"Under the heading of New Business, it was recommended: "That the Honorary Advisory Board of the Medical Association of Georgia hold its regular annual meeting on the evening preceeding the first House of Delegates meeting, the time and place of said meeting being left to the discretion of the chairman of the Board."

"Also recommended:

"That so far as possible all matters to be considered by the Board shall be presented to each Board member at least two weeks prior to the Board meeting." These recommendations were presented in the form of a motion and were duly seconded and adopted by the Board. A motion was then made to adjourn and carried."

Dr. Poer reported on a recent meeting of the Council on Medical Services, and Eustace Allen discussed the AMA policy on the corporate practice of medicine.

The next item of business was the discussion of the question of whether or not it is ethical for physicians to practice in association with cultists.

Dr. Callaway presented a report of the Professional Conduct Committee and there followed discussion by Callaway, Poer and Fowler.

It was moved and seconded (Chambers-Yeomans):

"That Council go on record as being unalterably opposed to the action of any member who associates himself (or herself) with any person practicing the healing arts who is not a licensed doctor of medicine except as specifically excluded by law." This motion was carried unanimously.

Dr. Chambers, chairman of the special committee appointed Saturday night to draft a report and a resolution to the House of Delegates, presented the special report to Council. The report is as follows:

"The officers and Council of the MAG have no desire to, in any way whatever, hinder the Medical College of Georgia in its development into the truly great teaching institution which it can and should become. Rather, the officers and Council of the MAG feel deeply their obligation to assist the Medical College of Georgia in every way possible to attain such a goal. Personal feelings, individual loyalties and personalities should not distort our judgment in trying to accomplish this task.

"The officers and Council of the MAG fully recognize that it is not its prerogative to interfere in the internal administrative affairs of the Medical College of Georgia. It is only when administrative or operative policies of the Medical College of Georgia threaten to or do violate professional or ethical principles to which the MAG is now and has been for years committed, that the policies of the Medical College of Georgia are of concern to us. The proposed operational policies of the Eugene Talmadge Memorial Hospital as a teaching unit of the Medical College of Georgia are of genuine interest to us now, since certain of these proposed operating policies would seem to violate a principle to which the MAG is committed.

"The basic problem confronting Council and officers of the MAG at this time involves the principle, of an institution, which in this instance will be a teaching unit of a state supported medical college, providing professional care to pay patients and collecting professional fees for this professional care. This is to be done under the banner of medical teaching necessity.

"Is it necessary and in the public interest, in order to provide instructional facilities for medical students and a resident training program, to have in a teaching facility pay-patients? That is, patients able to pay in full or in part professional fees. Or, on the other hand, are pay-patients necessary only to provide additional income for this teaching

facility? It matters not in principle whether the funds derived from professional fees are subsequently used in research or to pay utility bills. Is it in the good interest of medicine in Georgia and the Medical College of Georgia to compromise this principle? Will our final judgment in this matter stand the test of time?

"There are many points of discussion that may be raised in connection with the above mentioned principle.

"Numerically listed, they might be as follows:

"1. Will such operational policy represent corporate practice of medicine?

"2. Will those participating in such an operational policy violate the code of ethics of organized medicine?

"3. Will participation in such a program jeopardize the individual status of members of the AMA or members of specialty groups?

"4. What are the total possibilities of exploitation of doctor participants in such a plan?

"5. Is it necessary to have pay-patients for teaching material?

"6. Could this be another wedge in the advance of socialized medicine on a state level?

"7. Could the Eugene Talmadge Memorial Hospital fulfill its purpose as a teaching unit just as well without pay-patients?

"8. Are there other and possibly better ways of overcoming budget and deficit problems without disturbing the doctor-patient relationship and established methods of practice of medicine as we have known them in Georgia for over 100 years?

"9. If once this principle is compromised, are there any safe guards to protect it from further violations or exploitations from subsequent administrations at the Medical College of Georgia, or Board of Regents or even our Legislature?

"10. Can other hospitals, public or private, carry out the same type of care if we approve this hospital's providing professional care and collecting professional fees?

"11. Is the State of Georgia obligated through one of its agencies to provide hospital facilities for pay-patients in eastern Georgia? If so, why not in western Georgia, southern Georgia or northern Georgia?

"12. Will the operation of such a plan deprive the people of the Augusta area of the services of capable practitioners? Will not the need for these services be promptly met by individual practitioners not on a full time faculty?

"13. Will the plan as proposed deprive patients of free choice of physician?"

Dr. Chambers also presented the resolution, which reads as follows:

"WHEREAS, the Council of the Medical Association of Georgia wishes to commend the activity of the Joint Policy Committee on the proposed operational policies of the Eugene Talmadge Memorial Hospital,

"WHEREAS, the Council has nothing but praise for the officers of the Medical College of Georgia and the Board of Regents, nevertheless,

"WHEREAS, Chapter Seven, Section 5, of the Code of Medical Ethics of the AMA reads as follows: 'A physician should not dispose of his professional attainments or services to any hospital, laybody, organization, group or individual by whatever name called or however organized under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.'

"THEREFORE BE IT RESOLVED, that the proposed plan of operation of the Eugene Talmadge Memorial Hospital be approved insofar as the Medical College of Georgia and the Eugene Talmadge Memorial Hospital are concerned with the exception of portions of paragraphs four, five and six of the report.

"Paragraph four of the report denies pay patients who are citizens of Georgia free choice of physician. Paragraphs five and six of the report are in direct violation of Chapter Seven, Section Five of the Code of Medical Ethics, therefore,

"BE IT FURTHER RESOLVED, the Council of the MAG recommend that paragraphs four, five and six of the

report be disapproved insofar as they relate to the care of pay-patients.

"BE IT FURTHER RESOLVED, as the professional services will be rendered by salaried employees of a state supported institution the Council of the Medical Association of Georgia also recommends that only indigent patients be admitted to the Eugene Talmadge Memorial Hospital."

On a motion by Dillinger, seconded by Howard, it was moved that the report and resolution be adopted. After considerable discussion the report and resolution were adopted unanimously. It was then moved and seconded (Dillinger-Yeomans) that the report be presented by Dr. Chambers to the House of Delegates as a recommendation of Council.

The next item of business was the report of Charles S. Jones of the Insurance Board Subcommittee on Malpractice Insurance. His report concerning malpractice insurance outlined a tentative bill of particulars for Association activation of a group malpractice policy for Association members.

His brief outline was not intended to be the final form of an insurance program. It was simply a preliminary report and outline. On a motion (Poer-Dillinger) Council voted to endorse the activities of this subcommittee.

On a motion by Dr. Dillinger, the Council gave a rising vote of thanks to the work of the Auditing and Appropriations Committee and to its Chairman.

On a motion by Dr. Poer, seconded by Dr. Hatcher, it was moved that Council endorse and present the name of Eustace Allen to the House of Delegates to be endorsed by the House, for nomination as Vice-President of the AMA. This motion was unanimously carried.

On a motion by Dr. Fowler, seconded by Dr. Chambers, a rising vote of thanks was given Dr. and Mrs. Henry Tift, Dr. and Mrs. Milford B. Hatcher and Dr. and Mrs. Willard R. Golsan for their gracious hospitality at a social hour and dinner in entertaining the Council the night before, and the Secretary was instructed to write them a letter of appreciation.

An invitation was extended by Dr. Wright for the next meeting of Council to be held in Augusta.

Dr. Dillinger moved that the next meeting of the Council be tentatively set for March in Augusta, the final decision to be made by the Executive Committee. This motion was duly seconded and carried.

There being no further business the meeting was adjourned.

Special Session

House of Delegates

Macon, December 12, 1954

The first special session of the House of Delegates held Sunday, December 12, 1954, in the Walter Little Room of the Dempsey Hotel, Macon, was called to order by the Speaker of the House, Thomas Goodwin, Augusta, at 12:30 p. m., with the following remarks:

"Quoting from the MAG Constitution and By-Laws, Article VII, Sessions and Meetings; Section 3, Special Meetings: 'Special Meetings of either the Association or the House of Delegates may be called by a two-thirds vote of Council, 20 delegates or upon written petition of one-fourth of the members of the Association.'

"Quoting from the Fall meeting of Council Minutes dated November 4, 1954: 'Peter B. Wright then moved that a called meeting of the House of Delegates be held in approximately 30 days in Macon, if satisfactory arrangements can be made.'

"The motion for the called meeting was seconded and carried unanimously. It was also unanimously approved by Council that other items of Association business be added to the House of Delegates agenda upon approval of Council.

This special session was called to consider the policy for the operation of the Eugene Talmadge Memorial Hospital. These proposed policies are given as presented to the MAG as follows for your reference:

(1) The primary purpose of the hospital shall be development of medical knowledge and skills through organized programs of teaching. The development of such knowledge and skills is, of necessity, dependent upon the proficiencies developed while engaged in the care of patients under proper supervision and in observing and participating in medical research programs. With an increase in the student body, it has become increasingly clear that it is essential for the Medical College that the Teaching Program be developed under a nucleus of full-time faculty with supplemental clinical instructions through a part-time faculty.

(2) The Board of Regents recognizes the responsibility that it has accepted to develop a strong center for medical education in Augusta. The assumption of this responsibility places an obligation upon the Medical College to furnish services requested by physicians which will aid in the diagnosis and treatment of their patients. At the same time, it is recognized that this assistance will not take the form of competitive practice. It is suggested that the Board of Regents adopt a policy that the services of the Medical College and the Hospital will be available only upon the request of physicians or a medical agency responsible for the care of patients, and that such services will be used to supplement services available in the patient's home community. Every effort will be made to encourage physicians and medical agencies to send those patients who are of teaching interest or who need services that are not available in their local communities.

(3) Every effort will be made to see that present State Medical Programs, which are operating through local hospitals, clinics and centers, will be continued locally with the Medical College offering its facilities to the people of Georgia through their physicians for those problems which cannot be handled in the local community.

(4) We recommended that the Board of Regents accept the principle that no individual shall personally profit from the admission of the patient to this institution and therefore declare that the institution will operate with a closed staff which will be composed only of the faculty members of the Medical College and that no private patients will be admitted.

(5) We recommend that the Board of Regents recognize the fact that illness is no respecter of persons, that medical problems will present themselves among all social classes and that requests will be made for the admission of patients whose economic conditions will vary from the completely indigent to the patient who is able and anxious to pay for complete service. In the belief that it was not the intention of the Legislature to provide a hospital with free care for those patients who are able to pay, we recommend that the Board of Regents instruct the administrative staff to make such necessary rules and regulations to see that patients are classified according to their ability to pay for hospital services.

(6) The Medical College and Hospital staff should be instructed to set up a system whereby patients may also reimburse the State for medical services if their economic classification warrants such reimbursement. Such system must conform to existing laws and regulations and must be above reproach insofar as the ethics of the medical profession are concerned. It is also the expressed intention to see that any fees which might be collected for professional services are used in medical research and not for hospital expenses. The Board of Regents should state clearly that there will be no private diagnostic clinic operated in connection with the Medical College and the Hospital.

"Immediately following the fall meeting of Council, the Secretary's Office issued the Official Call of this House of Delegates meeting to all component county medical society presidents and secretaries in a letter dated November 5, 1954. A subsequent letter was so mailed to the component societies concerning the addition to the agenda of the 'Cultist Question.'

"I then call this special meeting of the Medical Association of Georgia House of Delegates in order to consider the two items so listed on the Official Call and other items of Association business as referred by Council."

Invocation was given by Secretary David Henry Poer, Atlanta. The Invocation as presented is as follows:

"Oh Lord, be with us through this meeting and guide our deliberations. Help us to promote the health and welfare of all the people in Georgia. Build in us a strong feeling of brotherhood to enable us to assist one another. Strengthen us to carry on the responsibilities with dignity and fairness. This we ask in Thy name. Amen."

Credentials Committee Chairman Henry Tift, Macon, gave a preliminary report to the House that 90 delegates were present at this time, and as 40 members of the House of Delegates constitute a quorum, a quorum was declared present.

Vice-Speaker Fred Simonton called the roll of Delegates from the Official Delegate Registration Roster. The roll call of Delegates by county as presented by Dr. Simonton indicated the following delegates as present:

ALTAMAHA: J. B. Brown, Jr.; BIBB: Henry Tift, Thomas L. Ross, Jr., Sam E. Patton, W. W. Baxley; BULLOCK: Candler-Evans; John Mooney, Jr.; BURKE:

Cleveland Thompson, Jr.; GEORGIA MEDICAL SOCIETY: T. A. Peterson, John L. Elliott, Ruskin King, Lee Howard, Jr., David Robinson; CHEROKEE-PICKENS: C. J. Roper; CLARKE-MADISON-OCONEE: Marion A. Hubert, James A. Green; CLAYTON-FAYETTE: T. J. Busey; COBB: Edward S. Marks, W. C. Mitchell; COFFEE: Sage Harper; DEKALB: W. A. Mendenhall; ELBERT: D. N. Thompson; FLOYD: W. M. Gilbert, C. J. Wyatt, Jr.; FULTON: John Turner, B. L. Shackelford, Hugh Hailey, Tully T. Blalock; McClaren Johnson, E. A. Bancker, Harold P. McDonald, Charles L. Jones, J. H. Hilsman, Lester Rumble, Chris McLoughlin, James H. Byram, A. O. Linch, Duncan Shepard, Bernard Wolff, Carl C. Aven, Stephen Brown, Hal Davison, A. H. Letton, C. W. Strickler, Margaret Wall, W. S. Dorrough, Edgar Woody, Jr., Lamont Henry; GORDON: Lewis R. Lang; HABERSHAM: J. J. Arrendale; HALL: E. L. Ward, Rafe Banks, Jr.; HANCOCK: C. S. Jernigan; JACKSON-BARROW: Alex B. Russell; JASPER: M. L. Greene; MERRIWETHER-HARRIS: W. P. Kirkland; MUSCOGEE: A. B. Conger, Jr., Elisha Cain, George M. Hutto, Frank B. Schley; NEWTON: J. C. Brown; OCMULGEE: M. F. Arnold; RANDOLPH-TERRELL: W. G. Elliott; RICHMOND: R. C. McGahee, J. L. Mulherin, Thomas Goodwin, Harry Pinson, David R. Thomas, George Wright; SOUTH GEORGIA: A. G. Little, F. G. Eldridge; SPALDING: Virgil Williams; STEPHENS: C. L. Ayers; SUMTER: Robert Pendergrass; THOMAS: George R. Dillinger, Kirk Shepard; TROUP: Charles T. Cowart, H. H. Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Fred H. Simonton, R. L. Patterson; WALTON: R. E. Wenzel; WARE: W. L. Pomeroy, Leo Smith; WASHINGTON: William Rawlings; WAYNE: J. W. Yeomans; WHITFIELD: Earl McGhee; WILKES: C. E. Willis, Jr.

Other members of the House of Delegates in attendance were: Peter B. Wright, H. Dawson Allen, Milford B. Hatcher, David Henry Poer, W. A. Selman, Ralph Chaney, Enoch Callaway, A. M. Phillips, W. F. Reavis, Wm. P. Harbin, Eustace Allen, C. H. Richardson, Sr., Mark Dougherty, Neal F. Yeomans, J. W. Chambers, D. Lloyd Wood, Bruce Schaefer, Lee Howard, Sr., J. G. McDaniel, H. G. Weaver, Ralph Fowler and Charles Andrews, Jr.

MAG members included Edgar Pund, President, Medical College of Georgia; Rufus Payne, Administrator, Eugene Talmadge Memorial Hospital; T. F. Sellers, Director, State Department of Health; and Harry Harper.

Also in attendance were Mrs. Margaret Thrasher and Messrs. Milton D. Krueger and John F. Kiser, of the headquarters office.

In a compilation of attendance taken from the official roll, 40 county medical societies were represented by their duly elected delegates. Forty county societies had no representation at this session and these counties are:

Baldwin, Bartow, Ben Hill-Irwin, Blue Ridge, Brooks, Carroll-Douglas-Haralson, Chattooga, Colquitt, Coweta, Crisp, Decatur-Seminole, Dooly, Dougherty, Emanuel, Forsyth, Franklin, Glynn, Grady, Gwinnett, Hart, Jefferson, Jenkins, Lamar, Laurens, Macon, McDuffie, Mitchell, Montgomery, Morgan, Polk, Rabun, Screven, Tattnall, Taylor, Telfair, Tift, Toombs, Southwest Georgia, Warren and Worth.

Of 137 Delegates eligible for this Session, 86 Delegates were in attendance. Twenty-seven other members of the House of Delegates were in attendance giving a grand total attendance of 113 members of the House of Delegates at this Session.

Remarks on rules and the order of business were then given by the Speaker of the House as follows abstracted:

"I also wish to remind you that according to the Constitution and By-Laws, Chapter III, Section 7: 'For the purpose of expediting proceedings the President shall appoint from the members of the House of Delegates the Reference Committees and other committees considered necessary.' As a one day session precludes the referring of resolutions to the usual reference committees, the chair will entertain directly such resolutions from the floor at the proper time as indicated by the chair.

Speaker Goodwin called for the reports, as listed in the Order of Business, concerning the proposed policies for the operation of the Eugene Talmadge Memorial Hospital.

The Speaker called on Secretary David Henry Poer for the report of Council. Dr. Poer then called on J. W. Chambers, LaGrange, Chairman of a Council Committee specifically appointed to give this report.

Dr. Chambers then gave the following report:

"The officers and Council of the MAG have no desire to, in any way whatever, hinder the Medical College of Georgia in its development into the truly great teaching institution which it can and should become. Rather, the officers and Council of the MAG feel deeply their obligation to assist the Medical College of Georgia in every way possible to attain such a goal. Personal feelings, individual loyalties and personalities should not distort our judgment in trying to accomplish this task.

"The officers and Council of the MAG fully recognize that it is not its prerogative to interfere in the internal administrative affairs of the Medical College of Georgia. It is only when administrative or operative policies of the Medical College of Georgia threaten to or do violate professional or ethical principles to which the MAG is now and has been for years committed, that the policies of the Medical College of Georgia are of concern to us. The proposed operational policies of the Eugene Talmadge Memorial Hospital as a teaching unit of the Medical College of Georgia are of genuine interest to us now, since certain of these proposed operating policies would seem to violate a principle to which the MAG is committed.

"The basic problem confronting Council and officers of the MAG at this time involves the principle of an institution's which in this instance will be a teaching unit of a state supported medical college, providing professional care to pay-patients and collecting professional fees for this professional care. This is to be done under the banner of medical teaching necessity.

"Is it necessary and in the public interest, in order to provide instructional facilities for medical students and a resident training program, to have in a teaching facility pay-patients? That is, patients able to pay in full or in part professional fees? Or, on the other hand, are pay-patients necessary only to provide additional income for this teaching facility. It matters not in principle whether the funds derived from professional fees are subsequently used in research or to pay utility bills. Is it in the good interest of medicine in Georgia and the Medical College of Georgia to compromise this principle? Will our final judgment in this matter stand the test of time?

"There are many points of discussion that may be raised in connection with the above mentioned principle.

"Numerically listed, they might be as follows:

"1. Will such operational policy represent corporate practice of medicine?

"2. Will those participating in such an operational policy violate the code of ethics of organized medicine?

"3. Will participation in such a program jeopardize the individual status of members of the AMA or members of specialty groups?

"4. What are the total possibilities of exploitation of doctor participants in such a plan?

"5. Is it necessary to have pay-patients for teaching material?

"6. Could this be another wedge in the advance of socialized medicine on a state level?

"7. Could the Eugene Talmadge Memorial Hospital fulfill its purpose as a teaching unit just as well without pay-patients?

"8. Are there other and possibly better ways of overcoming budget and deficit problems without disturbing the doctor-patient relationship and established methods of practice of medicine as we have known them in Georgia for over 100 years?

"9. If, once this principle is compromised, are there any safeguards to protect it from further violations or exploitation from subsequent administrations at the Medical College of Georgia, or Board of Regents or even our Legislature?

"10. Can other hospitals, public or private, carry out the same type of care if we approve this hospital's providing professional care and collecting professional fees?

"11. Is the State of Georgia obligated through one of its agencies to provide hospital facilities for pay-patients in eastern Georgia? If so, why not in western Georgia, southern Georgia or northern Georgia?

"12. Will the operation of such a plan deprive the people of the Augusta area of the services of capable practitioners? Will not the need for these services be promptly met by individual practitioners not on a full time faculty?

"13. Will the plan as proposed deprive patients of free choice of physician?"

Upon completion of the report, Dr. Chambers then presented a resolution which was adopted by Council December 12, 1954 and was recommended by Council for approval by the House of Delegates at this Session. The resolution is as follows:

"WHEREAS, the Council of the Medical Association of Georgia wishes to commend the activity of the Joint Policy Committee on the proposed operational policies of the Eugene Talmadge Memorial Hospital,

"WHEREAS, the Council has nothing but praise for the officers of the Medical College of Georgia and the Board of Regents, nevertheless,

"WHEREAS, Chapter Seven, Section Five, of the Code of Medical Ethics of the AMA reads as follows: 'A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual by whatever name called or however organized under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.'

"THEREFORE BE IT RESOLVED, that the proposed plan of operation of the Eugene Talmadge Memorial Hospital be approved insofar as the Medical College of Georgia and the Eugene Talmadge Memorial Hospital are concerned with the exception of portions of paragraph four, five and six of the report.

"Paragraph four of the report denies pay patients who are citizens of Georgia free choice of physician. Paragraphs five and six of the report are in direct violation of Chapter Seven, Section Five of the Code of Medical Ethics, therefore,

"BE IT FURTHER RESOLVED, the Council of the MAG recommends that paragraphs four, five and six of the report be disapproved insofar as it relates to the care of pay patients.

"BE IT FURTHER RESOLVED, as the professional services will be rendered by salaried employees of a state supported institution the Council of the Medical Association of Georgia also recommends that only indigent patients be admitted to the Eugene Talmadge Memorial Hospital."

Speaker Goodwin called on Enoch Callaway, LaGrange, MAG member of the Joint Policy Committee for a report concerning that committee which had been made available to all Delegates. This report was in substance the projected plans for the operation of the hospital as submitted by the Joint Policy Committee.

The Speaker called on the Honorary Advisory Board (Past Presidents) Chairman, Enoch Callaway, to present the report from the Honorary Advisory Board on the Talmadge Memorial Hos-

pital operational policies reading as follows:

"The projected plans and recommendations were discussed paragraph by paragraph as presented to the Board. Discussion and action ensued as follows:

It was moved, seconded and approved that paragraph No. 1 be received as information.

Paragraph No. 2 was discussed at length and it was moved and seconded that paragraph No. 2 be approved. This motion was adopted.

Paragraph No. 3 was read and a motion was made that it be adopted. The motion was duly seconded and approved.

Paragraph No. 4 was read and it was decided to defer action on Paragraph No. 4 until Paragraph No. 5 and No. 6 were fully discussed.

"Paragraph No. 5 and No. 6 were read and discussed freely, and it was finally decided and so moved that the Honorary Advisory Board of the Medical Association of Georgia is in sympathy with the aims and purposes as outlined by the recommendations offered by the Joint Policy Committee composed of members from the Board of Regents, the State Board of Health and the Medical Association of Georgia; however, due to the fact that certain matters in the recommendations have not been clarified by the American Medical Association as to their ethical status, it is recommended by the Honorary Advisory Board that action be withheld until these matters can be acted upon by the AMA at its next regular meeting. The motion was duly seconded and carried by the Board."

Speaker Goodwin then called on Edgar Pund, President of the Medical College of Georgia to present and explain the proposed policies for the operation of the Eugene Talmadge Memorial Hospital.

Speaker Goodwin advised the delegates that upon completion of Dr. Pund's report the chair would entertain questions to Dr. Pund from the floor concerning the policies discussed by him. The Speaker also introduced Rufus Payne, Administrator of the Eugene Talmadge Memorial Hospital, and T. F. Sellers, Director of the State Health Department, and advised the delegates that questions might also be directed to Drs. Payne and Sellers.

Dr. Pund's report included remarks on the following aspects of the projected plans: Reasons for the hiring of a full time faculty; legal problems involved; disposition of professional fees received by the hospital; policies of other medical schools in this connection; and other matters as they pertain to the professional aspects of the plans as they will relate to the physicians of Georgia.

Drs. Pund, Payne and Sellers then answered questions from the floor.

Speaker Goodwin then held that the rest of the meeting would be conducted in Executive Session. He further ruled that any member whose name was not called in the Official Roll would be excused from the meeting at this time.

The Speaker then reread the resolution as presented by Council to the House. The resolution was seconded by George Dillinger, Councilor.

Speaker Goodwin then called for debate on the resolution and made known his desire to limit the debate to approximately one hour if possible.

The following members of the House were recognized by the chair in the order listed below during the debate on the Council presented resolution.

C. H. Richardson, Sr., spoke in favor of the resolution; Eustace Allen, in favor of the resolution; John Turner called for a caucus of the Fulton County delegation in an anteroom at that time; John Mooney, in favor of the resolution; R. C. McGahee, against the resolution, because he stated the entire Richmond County delegation was so instructed.

R. C. McGahee then offered a substitute motion as follows:

"RESOLVED that this special meeting of the House of Delegates of the MAG be regarded as an informational meeting only and that all delegates return to their respective societies for reinstruction for the next meeting of the House of Delegates in May in Augusta when the matter would be considered a second time." The motion was seconded by David R. Thomas, Jr.

John Turner spoke in favor of the resolution and against the substitute motion. He reported that the Fulton delegation had met and was in favor of supporting Council's resolution.

David R. Thomas expressed the idea that while the Council should be considered the guide for the House of Delegates, the Richmond County Medical Society Delegates could not vote otherwise than instructed.

Charles Jones called for the question and the substitute motion was brought to a vote and defeated by a voice vote and the Speaker so ruled.

Speaker Goodwin then reread the Council presented resolution and a vote was taken. A vote as tabulated with 71 Delegates in favor of the resolution and 23 against the resolution was recorded. Speaker Goodwin then declared the Council resolution carried by majority.

Charles Jones then moved, seconded by J. H. Hilsman, that the following resolution be adopted.

"WHEREAS, the cost of a medical education is prohibitive if fully borne by the student, and

"WHEREAS, all schools of medicine are seeking ways and means within ethical limits to secure funds to help defray this cost; and

"WHEREAS, the President of the Medical College of Georgia has requested the Medical Association of Georgia to help them in finding some acceptable and ethical method of providing medical care for the sick who will come to the hospital seeking professional care;

"BE IT RESOLVED: that it is incumbent upon the Medical Association of Georgia to offer help to the President of the Medical College of Georgia, and

"THAT the President of the Medical Association of Georgia be requested by the Speaker of the House of Delegates to appoint a committee to consult with and assist the President of the Medical College of Georgia and the Joint Policy

Committee to work out a plan which will be acceptable to the Eugene Talmadge Memorial Hospital and also to the Medical Association of Georgia."

After discussion on the resolution a vote was taken. The vote as tabulated was 53 in favor of the resolution and 25 against the resolution; it was recorded and the Speaker declared the resolution carried by a majority vote.

Speaker Goodwin then brought before the House the next order of business which concerned the question of whether or not it is ethical for members to practice in Association with cultists.

Secretary David Henry Poer, presented a report of Council on this question in which the following resolution was recommended for adoption by the House:

"RESOLVED that the House of Delegates of the MAG go on record as being unalterably opposed to the action of any member who associates himself (or herself) with any physician practicing the healing arts who is not a licensed doctor of medicine, except as specifically excluded by law."

Enoch Callaway, Honorary Advisory Board Chairman rose to give the report of the Honorary

Advisory Board on this matter, and seconded the motion for the adoption of the resolution.

Dr. Callaway described the action of the Honorary Advisory Board in substance.

After discussion of the resolution before the House by Carl C. Aven and E. T. McGhee, the motion was brought to a vote. A voice vote indicated unanimous approval by the House, and the Speaker so ruled.

The last item on the detailed order of business concerned other business referred by Council as reported by Secretary David Henry Poer. Dr. Poer presented a Council recommendation to the House as follows:

RESOLVED that the House of Delegates of the Medical Association of Georgia place the name of Eustace Allen, Atlanta, in nomination for the office of Vice-President of the American Medical Association.

A voice vote of unanimous approval was given this recommendation and Speaker Goodwin so ruled.

Speaker Goodwin then entertained a motion for adjournment which was made, seconded and carried.

Second Call For Scientific Exhibits

To Be Presented At
The 105th Annual Session,
Medical Association of Georgia
May 1-4, 1955 Bon Air Hotel, Augusta, Ga.

FOR AN APPLICATION WRITE TO:

Dr. Hoke Wammock
Medical College of Georgia
Augusta, Georgia

ANNOUNCEMENTS

The American Academy of Allergy Postgraduate Teaching Program—New York, N.Y., February 4, 5, 6, 1955. One day will be devoted to each of the following subjects: Contact Dermatitis and Asthma with Panel Discussion on those subjects on the third day. *The Annual Meeting and Scientific Session of The American Academy of Allergy* will be held February 7, 8, 9, 1955, at the Hotel Statler, New York City. For further information contact The American Academy of Allergy, 208 East Wisconsin Avenue, Milwaukee 2, Wisconsin.

American College of Chest Physicians, Council on Undergraduate Medical Education 1955 College Essay Award Contest—Three cash awards (\$250, \$100 and \$50) for best contribution, prepared by undergraduate medical student studying for a degree in medicine, on any phase of the diagnosis and treatment of chest diseases (heart and/or lungs). For further information contact the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Ill. Entry deadline is April 10, 1955.

Eighth Annual Postgraduate Course on Diseases of the Chest, American College of Chest Physicians—Bellevue-Stratford Hotel, Philadelphia, Pennsylvania, March 7-11, 1955. Tuition, \$75. For further information, write to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Ill.

Seventh Annual Meeting of the American Academy of Forensic Sciences—Biltmore Hotel, Los Angeles, February 17, 18, 19, 1955. Further information may be obtained by writing Dr. W. J. R. Camp, University of Illinois College of Medicine, 1853 W. Polk Street, Chicago, Illinois.

Fifty-first Annual Congress on Medical Education and Licensure—Palmer House, Chicago, February 5-8, 1955. For further information write to the Council on Medical Education and Hospitals of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Harvard University School of Public Health announces Public Health Scholarships for academic year 1955-56. A catalogue of the School, Admission and Scholarship applications and further information may be obtained by writing the Secretary, Harvard School of Public Health, 55 Shattuck Street, Boston 15, Mass. Applications must be returned by March 1, 1955.

Joint Meeting of the Southeastern Surgical Congress and the Atlanta Graduate Medical Assembly—Atlanta, February 21-24, 1955. For further information

write Dr. George W. Fuller, 478 Peachtree Street, N.E., Atlanta, Ga.

Twenty-third Venereal Disease Postgraduate Course—Tulane Medical School, New Orleans, January 31-February 4, 1955. No tuition will be charged for the course which is designed to acquaint the practitioner with the latest developments. Application for admission should be made immediately to Dr. Clifford Grulee, Jr., Director of the Division of Graduate Medicine of Tulane University of Louisiana, 1430 Tulane Avenue, New Orleans, La.

SOCIETIES

The SIXTH DISTRICT MEDICAL SOCIETY met December 1, 1954, at the State Health Building, Macon. The meeting was called to order by George Alexander, Forsyth, president. Guests at this meeting included Peter B. Wright, Augusta, President of the Medical Association of Georgia; Edgar R. Pund, Augusta, President of the Medical College of Georgia; and Mr. John F. Kiser, Atlanta, Assistant Executive Secretary of the MAG.

The scientific program was first on the agenda. Braswell Collins, Macon, spoke on the eye, ear, nose and throat causes of headache and some of the diagnostic and therapeutic procedures applicable to the same; Ed Fincher, Emory University, discussed the diagnosis of brain tumors; J. P. Woodhall, Macon, reported on cancer of the lung in central Georgia; and the final speaker on the program was Hugh Sealy, Macon, who discussed coronary artery disease.

Peter B. Wright then addressed the meeting briefly. Mr. Kiser mentioned in a short talk the question of reinsurance, life membership in the AMA, professional conduct and public relations. Dr. Pund discussed the present policies in regard to the Eugene Talmadge Memorial Hospital.

The following officers were elected for the year 1955: president, C. H. Richardson, Jr., Macon; vice-president, James O'Daniel, Dublin; secretary-treasurer, Herbert O. Olnick, Macon; councilor from the Sixth District, Henry H. Tift, Macon.

Following the meeting, the members attended a social hour and dinner at the American Legion Club.

The BARTOW COUNTY MEDICAL SOCIETY met in December at the home of Dr. and Mrs. William B. Quillian in Cartersville. The following officers were elected to serve in 1955: president, W. E. Wofford; vice-president, J. W. Stanford; secretary-treasurer, A. L. Horton. Dr. Horton has been in practice for 40 years, and in appreciation of that fact was elected to life membership in the society. William B. Dillard, Jr., was elected to the House of Delegates of the MAG, with Ross Whatley and William Quillian, Cartersville, as alternates. William Dillard, Harvey

Howell and William Quillian will compose the society's Board of Censors for the next quarter it was also announced.

The annual meeting of the TRI-COUNTY MEDICAL SOCIETY was held in Arlington recently; R. B. Quattlebaum presided. With the revision and adoption of a new constitution and by-laws, the name was changed to the SOUTHWEST GEORGIA MEDICAL SOCIETY, which is to include the following counties: Baker, Calhoun, Clay, Early and Miller. C. K. Sharp, Arlington, was made a Life Member of the society. The following officers were elected for the year 1955: president, W. C. Baxley, Blakely; vice-president, H. J. Merritt, Colquitt; secretary-treasurer, R. B. Quattlebaum, Fort Gaines; Board of Censors—J. W. Merritt, Colquitt, 1955; W. O. Shepard, Bluffton, 1956; J. G. Standifer, Blakely, 1957. The new by-laws provide that the president is the delegate to the MAG House of Delegates, and the secretary, the alternate.

The TRI-COUNTY MEDICAL SOCIETY (Carroll-Douglas-Haralson) met at the Tanner Memorial Hospital, Carrollton, on December 6, 1954. The following physicians were elected to office for 1955: J. W. Watts, Bowdon, president; Francis M. Parks, Carrollton, president-elect; E. V. Patrick, vice-president; and D. S. Reese, Carrollton, secretary-treasurer.

The GEORGIA MEDICAL SOCIETY met in Savannah on December 14 and elected the following officers: Hiram F. Sharpley, president-elect; Charles L. Prince, vice-president; W. W. Osborne, secretary; and Ralph O. Bowden, treasurer. Samuel F. Rosen is the new president.

The November meeting of the CHATTOOGA COUNTY MEDICAL SOCIETY was held at the Riegeldale Tavern in Summerville. H. A. Goodwin was host to the society at this meeting.

The FULTON COUNTY MEDICAL SOCIETY held its annual meeting at the Academy of Medicine, Atlanta, on December 16, 1954. B. L. Shackelford, Atlanta, is the new president of the society; McLaren Johnson, president-elect; Charles S. Jones, vice-president; Tully T. Blalock, secretary-treasurer; and Duncan Shepard, judicial council member. James H. Byram and Linton H. Bishop, Jr., were chosen senior and junior trustees respectively. A certificate of appreciation was awarded to each of the following: Carl C. Aven, Gerald R. Cooper, E. E. Mendell, Allen Bunce, A. O. Linch, Jack C. Norris, Walker Jernigan, Marion C. Pruitt and Mrs. A. Worth Hobby. A memorial service for the members of the society who died during the past year was conducted by Jack C. Norris. Those members honored were I. T. Catron, J. H. Crawford, J. L. Pittman, J. R. White, J. T. Hutchins, C. H. Paine, Lewie H. Muse, William Goldsmith and Clinton Reed. John Turner, retiring president, reported on activities of the society in the past year and noted that there has been a 50 per cent increase in attendance at meetings.

James A. Elkins, Columbus, was elected president of the MUSCOGEE COUNTY MEDICAL SOCIETY at a meeting held November 23, 1954, in Columbus. Other officers elected were Hugh J. Bickerstaff, president-elect; and Robert H. Vaughan, secretary-treasurer. Franklin Edwards was reappointed medical forum chairman, and A. B. Conger was named Editor of the *Bulletin of the Muscogee County Medical Society*. Jack Davidson, Harry Brill, William Cook, Luther Roberts, George Hutto, Roy Gibson and Dave Berman were named to the public relations and projects committee for 1955.

The RANDOLPH-TERRELL MEDICAL SOCIETY elected officers for 1955 at the December meeting held at Patterson Hospital in Cuthbert. Fred Simons, Dawson, was named president; F. S. Rogers, Coleman, vice-president; Robert B. Martin, III, Cuthbert, secretary and treasurer; and Walter D. Martin, Dawson, delegate. Elected to the Board of Censors were A. R. Sims, Richland; Walter D. Martin, Dawson; and F. S. Rogers, Coleman.

THOMAS COUNTY MEDICAL SOCIETY held its quarterly meeting in Thomasville recently. Speakers at this meeting were Edgar Woody, Jr., Atlanta, Editor of the *Journal of the Medical Association of Georgia*, who spoke on "Hypertension," and Sam Wilkins, Jr., of the Winship Clinic of Emory University, whose topic was "Surgery and Treatment of Carcinoma of the Cervix." Officers elected at this meeting are as follows: M. B. Wine, Thomasville, president; Roy Stinson, vice-president; and Julian Neel, Thomasville, secretary-treasurer. Following the meeting, there was a buffet supper and the annual doctors and nurses dance at Glen Arven Country Club.

The WARE COUNTY MEDICAL SOCIETY meet in Waycross at the Ware Hotel in December. Samuel Victor, Waycross, was named president of the society for 1955. Floyd E. Davis is the new vice-president; Arthur M. Knight, Jr., Waycross, was re-elected secretary-treasurer. W. L. Pomeroy and Leo Smith were elected to the House of Delegates of the MAG; alternate delegates are Ansley Seaman and Vilda Shuman. W. F. Reavis, Lovick W. Pierce and Wilbur L. Flesch were hosts to the meeting which was highlighted by a turkey banquet.

DEATHS

WILLIAM E. BARFIELD, Savannah, 42, died November 29, 1954, in a Savannah hospital of a heart attack.

Dr. Barfield was born in Atlanta, August 30, 1912. He was educated in the public Schools of Atlanta and was graduated from Emory University. He received his M.D. degree from Emory in 1936. Dr. Barfield went to Savannah in 1938 as a resident

at St. Joseph's Hospital; he was later in private practice in Savannah until 1941 when he went on active duty with the 101st Airborne Division of the U. S. Army. As division surgeon with the rank of lieutenant colonel, Dr. Barfield was awarded the Bronze Star with oak leaf cluster, the Purple Heart and the French Croix de Guerre with silver star. His European Middle Eastern Theater ribbon carried the invasion arrow and four battle stars.

After his military service he practiced medicine in Jackson before returning to Savannah in 1950.

Funeral services were held December 1, 1954, with burial in Bonaventure Cemetery. Members of the Georgia Medical Society were honorary pallbearers.

LEON E. BRAWNER, St. Simons Island, 66, died December 4, 1954, in Brunswick. Dr. Brawner had been in ill health for several years; he had retired to St. Simons Island from Atlanta eight years ago.

Dr. Brawner was born in Alabama. He graduated from Emory University in 1911 and practiced in Cairo until World War I. He was a senior fellow of the American Academy of Otorhinolaryngology.

Funeral services were held December 5 at the First Baptist Church of St. Simons Island, of which he was a deacon, with burial in West View Cemetery, Atlanta. Glynn County Medical Society members were honorary pallbearers.

EDWARD BURTON CLAXTON, Dublin, 70, died November 24, 1954, at Johns Hopkins Hospital, Baltimore, Md., of complications following surgery.

Dr. Claxton, a 1905 graduate of Maryland Medical College (now the University of Maryland School of Medicine), practiced for several years at Kite before moving to Dublin in 1914. He established and operated Claxton Sanatorium, a 65 bed private hospital in Dublin.

He was a past president of both the Laurens County Medical Society and Sixth District Medical Society. He also held membership in the Association of Railroad Surgeons, Southern Medical Society and International College of Surgeons. At the time of his death he was also chairman of the City Board of Education of Dublin.

Dr. Claxton is survived by his widow, the former Irene Robertson, three daughters and one son. Dr. M. Z. Claxton, Dublin, is his brother.

THOMAS FLETCHER HARPER, Coleman, 73, died suddenly at his home November 27, 1954.

Dr. Harper was a graduate of the Atlanta College of Physicians and Surgeons, which later became Emory University School of Medicine; except for two years practice in Weston, he had practiced in Coleman for 49 years.

A past president of the Third District Medical Society and the Randolph-Terrell County Medical Society, Dr. Harper was a steward and trustee of the Coleman Methodist Church.

Funeral services were held Sunday, November 28, 1954, at Coleman Methodist Church, with burial in Coleman Cemetery.

LILLIAN INGRAM, Albany, 46, died November 15, 1954, in Albany. Dr. Ingram had practiced pediatrics in Albany for the last nine years.

She was born in Montgomery, Alabama, August 29, 1908, and later moved to Bainbridge. She graduated from Bainbridge High School and the University of Alabama. Dr. Ingram received her M.D. degree from the University of Chicago in 1936. She was at Contagious Hospital, Muncie, Illinois, as intern and resident from 1937 to 1941. Dr. Ingram was resident physician at the Henrietta Egleston Hospital for Children, Atlanta, for three years. For a short time before coming to Albany, Dr. Ingram was in private practice in Atlanta.

Funeral services for Dr. Ingram were held at the First Baptist Church of Albany on November 17. The honorary escort was composed of members of the Dougherty County Medical Society, Dougherty County Health Department and the nurses and personnel of Phoebe Putney Hospital. Burial was in Oak City Cemetery, Bainbridge.

J. E. JOHNSON, SR., Elberton, 92, died at his home in Elberton on November 26, 1954. Funeral services were held November 27 in the First Methodist Church, with burial in Elmhurst Cemetery. Members of the Elbert County Medical Society were honorary pallbearers.

Dr. Johnson was born in Hall County on September 14, 1862, and came to Elberton to practice medicine soon after graduating from the University of Louisville in 1893. He was in active practice for more than 50 years, retiring only a few years ago because of his advancing age.

Dr. Johnson was an active member of the First Methodist Church and at one time or another held practically every office his church offers to laymen.

He is survived by his wife, the former Georgia Heard; a son, Dr. J. E. Johnson, Jr.; a brother, Dr. A. S. Johnson, Sr.; all of Elberton; two grandsons Dr. J. E. Johnson, III, of Baltimore; Parks Johnson, Elberton, and a granddaughter, Roberta Anne Johnson, Elberton.

CLIFFORD AUGUSTINE PEACOCK, Columbus, 68, died December 13, 1954, of a heart attack. Dr. Peacock was engaged in the active practice of medicine at the time of his death.

He was born in Buena Vista, Ga., October 6, 1886, the son of the late Mr. and Mrs. Robert Howell Peacock. Dr. Peacock attended Columbus public schools and graduated from Tulane University in 1911. His postgraduate medical work was done at Bellevue Hospital in New York City.

Following overseas duty with the U. S. Army in World War I, Dr. Peacock began his practice in Columbus in 1919.

Dr. Peacock was a member of the Protestant Episcopal Church, the Academy of Otolaryngology, and for many years he served as a member of the Muscogee County Board of Health.

Dr. Peacock is survived by his wife, the former Nell Ramage, and one son, Clifford A. Peacock, Jr.

PERSONALS

T. F. ABERCROMBIE, Atlanta, delivered the main address at the recent dedication of the Carroll County Health Center. He spoke on "The History of the Public Health Movement in Carroll County" and in his talk paid tribute to the late Henry Fauntleroy Harris, first director of the Georgia Department of Public Health and a native of Carrollton. A plaque to Dr. Harris' memory was placed in the Center by the Carrollton Kiwanis Club. T. F. SELLERS was to make an address but was unable to attend the ceremonies; S. W. RUTLAND took his place on the program.

GEORGE H. ALEXANDER, Forsyth, was the moderator of the panel discussion held in Monroe in November. The topic under discussion was "Heart Disease and High Blood Pressure." Others participating were THOMAS L. ROSS, HENRY TIFT and BEVERLY FORESTER, all of Macon.

ALBERT W. BAILEY, Augusta, has returned from a tour of duty in the armed forces to his position as instructor in pathology at the Medical College of Georgia. Dr. Bailey graduated from the Medical College of Georgia and received his training in pathology at the Medical College and at the Naval Hospital in Norfolk, Virginia.

W. B. BATES, JR., and W. L. FLESCHE, Waycross, attended a course in "Human Infertility" at the New York University Bellevue Hospital Medical Center.

V. L. BRYANT, Wadley, was among the company surgeons and employees of the Central of Georgia Railway Company who were enrolled in the quarter century service club recently. His name was placed on the roll of honor, and he was given a pin emblematic of his service with the company.

P. F. BROWN, JR., Gainesville, was made a Fellow of the American College of Surgeons at the recent clinical meeting of the College in Atlantic City.

JOHN D. CAMPBELL, Atlanta, read a paper before the Neuropsychiatric Section of the American Medical Association meeting in Miami on December. The title of his paper was "Manic-Depressive Disease in Children."

Four Augusta surgeons were made Fellows of the American College of Surgeons recently. They are AUGUSTIN S. CARSWELL, WILEY STEWART FLANAGAN, JOHN EMILE HUMMELL and R. E. LEONARD.

Two Columbus physicians have been made Fellows of the American Academy of Pediatrics. They are JOSEPH B. CHASTAIN and A. J. KRAVITZ.

HOWARD COE, Brunswick, was re-elected chief of staff of the Brunswick Hospital at its annual staff meeting in December. HAYWOOD MOORE was re-elected vice president, and BERT MALONE, secretary of the staff. C. S. BRITT was named a member of the executive committee.

FRED J. COLEMAN and ROBERT T. ANDERSON, Dublin, held open house at their new building at 106 Church Street, Dublin, on November 21st. The public was invited to come and see the new offices. Dr. Coleman was recently renamed chief of staff of the Laurens County Hospital. JAMES F. O'DANIEL is vice chief of staff, and NELL KENNEY is secretary.

Two Augusta physicians have been elected to membership in Alpha Omega Alpha, national honor medical society. They are WILLIAM J. CRANSTON, Medical College of Georgia, class of 1908, and CURTIS H. CARTER, class of 1938. Dr. Cranston is at present clinical professor of medicine at the Medical College, and Dr. Carter is assistant professor of medicine.

NORMAN J. CROWE, Sylvester, was guest speaker at a recent meeting of the Vocational Office Training Club of the Sylvester High School. Dr. Crowe led an informative discussion on Mental Health.

EDGAR M. DUNSTAN, Atlanta, has been given the first annual Aven Award for activity in civic affairs. The award was given by C. C. AVEN, Atlanta, and Mrs. Aven, at the Annual meeting of the Fulton County Medical Society, January 6, 1955.

F. G. ELDRIDGE, Valdosta, radiologist, was the principal speaker at a recent meeting of the Cairo Rotary Club. Dr. Eldridge's topic was the treatment of cancer.

CHARLES W. FARMER, JR., Newnan, announces the removal of his office to 43 Jefferson Street with practice limited to Eye, Ear, Nose and Throat.

T. GRAY FOUNTAIN and O. GREY RAWLS, JR., announce the opening of their offices in the Medical Building, 403 Broad Avenue, Albany, with practice limited to surgery.

WILLIAM F. FRIEDEWALD, Atlanta, announces the removal of his office to the Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E., for the practice of internal medicine and allergy.

L. H. GRIFFIN, Claxton, announces the opening of a 16-bed hospital on Liberty Street at McLain Avenue, December 12, 1954. Dr. Griffin will have his offices at "Griffin Clinic" also. Facilities include 10 beds for white patients and six for colored patients, reception rooms, nursery, kitchen, five bathrooms, separate operating and delivery rooms, examining rooms and laboratory.

ROBERT B. GREENBLATT, Augusta, participated in a recent symposium on constructive medicine in aging. The seminar was held December 14 in Cincinnati; Dr. Greenblatt's subject was "Metabolic and Psychosomatic Disorders in Menopausal Women."

WALTER G. HACKETT, Rome, who has been serving as chief of surgery at the 1707th U. S. Air Force Hospital, Palm Beach A. F. B., Fla., has returned to

Rome after being released from active duty. Dr. Hackett has rejoined the Harbin Clinic staff.

J. HAROLD HARRISON, Atlanta, addressed the Fulton County Medical Society at the December meeting on "Vascular Grafting in Obliterative Arterial Disease." Dr. Harrison said eight artery grafts have been performed at Grady Memorial Hospital with only one of them unsuccessful. This operation was first performed in France four years ago, and was first done here over a year ago.

At the second in a series of medical forums held at the Ninth Street Branch YMCA in Columbus, R. M. HASKINS, Columbus, lectured on the subject, "Common Diseases of Women."

LAMONT HENRY, Atlanta, announces the removal of his offices to the Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E., for the practice of internal medicine and cardiology.

A. C. HOBBS, JR., Columbus, has recently been certified by the American Board of Ophthalmology.

JOHN M. HODGES, Marietta, has resumed his practice of surgery in Marietta after two years service with the U. S. Army. Dr. Hodges is in his former office at 301 Cherokee Street.

JOHN STEPHEN INMAN, Albany, was married January 9, 1955, to Miss Willa Mae Brickle, daughter of Mr. and Mrs. Harry L. Brickle of Lenox.

November 14, 1954, was designated as "Dr. Kay Day" in Byron. A reception was held at the Byron Auditorium and Dr. and Mrs. J. B. Kay were presented with a beautiful silver service by the people of Byron and other Middle Georgia communities. Dr. Kay has practiced in Byron for 35 years, and a good many of the 596 persons signing the guest register were babies he had delivered.

ARTHUR M. KNIGHT, JR., Waycross, has been elected to membership in the American College of Physicians. Dr. Knight is a Diplomate of the American Board of Internal Medicine, Chief Clinician at the Ware County Hospital Clinic and secretary-treasurer of the Ware County Medical Society. He is an officer of the Georgia Heart Association and a Contributing Editor of the *Journal of the Medical Association of Georgia*.

Five Atlanta physicians have been made Fellows of the American College of Surgeons: PHILIP I. KRUGMAN, JOHN T. MAULDIN, JOHN H. RIDLEY, JESSE WILLIAMS VEATCH and CHARLES P. YARN, JR. Dr. Krugman, now practicing obstetrics and gynecology, is a 1941 graduate of Emory University School of Medicine; Dr. Mauldin, general surgeon, graduated from Emory in 1939; Dr. Ridley, Emory, class of 1939, is a practicing gynecologist and urologist; Dr. Veatch graduated from Emory in 1940 and practices general surgery; and Dr. Yarn is another

Emory graduate, class of 1945, now practicing plastic and reconstructive surgery.

TED F. LEIGH, ROBERT P. KELLY and H. STEPHEN WEENS, Emory University, received an award in the "Clinical Investigation" category at the 40th Annual Meeting of the Radiological Society of North America held in Los Angeles in December, for their exhibit entitled "Occurrence of Spinal Osteomyelitis in Urinary Tract Infections." Drs. Leigh, Kelly and Weens also presented a paper entitled, "Spinal Osteomyelitis Associated with Urinary Tract Infections," and Dr. Weens was one of four panel members in a symposium on Cine-radiography.

LEONARD LONG, Atlanta, also received an award at the meeting of the Radiological Society of North America. It was in the "Gadget Row" category; a "Wriggelator," a device for immobilizing infants for radiographic and other medical procedures.

BRUCE LOGUE, Atlanta, addressed the Chester County (South Carolina) Medical Society at its annual lectureship. The afternoon talk was "Management of Cardiac Arrhythmia" and the evening address was "Recent Advances in the Management of Hypertension."

ROBERT A. MATTHEWS, Albany, has been appointed Chief of Anesthesia at the Phoebe Putney Hospital in Albany. Dr. Matthews is a native of Anderson, Indiana, and a graduate of the Medical College of Georgia. He served his residency at the University Hospital in Augusta.

HAROLD P. McDONALD, Atlanta, made the presentation of the portrait of the late Frank K. Boland, Sr., which is to hang in the doctors' room of the Crawford W. Long Memorial Hospital. Dr. McDonald is chairman of the Frank Boland Memorial Committee, and the presentation was made at the quarterly meeting of the medical staff of the hospital.

M. T. McGOOGAN, JR., Fitzgerald, has been made a Fellow of the American College of Surgeons.

J. C. METTS, Savannah, is the first president of the staff of the new Memorial Hospital of Chatham County. He was elected to the post at a staff organizational meeting attended by 140 doctors and dentists. Other officers named were: J. H. PINHOLSTER, vice-president, and CHARLES L. PRINCE, secretary-treasurer. The \$4,500,000 hospital is expected to be ready to receive patients by July 1, 1955.

GEORGE T. NICHOLSON, Cornelia, announces the removal of his office from 17 Clarkesville Street to 120 Fore Acre Street in Cornelia.

JACK C. NORRIS, Atlanta, has assumed office as councilor of the Southern Medical Association. Dr. Norris will represent Georgia in this capacity for the next five years.

JOHN B. O'NEAL, Elberton, has been elected to serve as the mayor of Elberton for the next two

years. D. V. BAILEY was elected to the City Council of Elberton in the same election; he will serve for one year.

J. C. PATTERSON, Cuthbert, was the speaker at a recent meeting of the Blakely Rotary Club. Dr. Patterson, who with his wife toured Europe last summer, told of his travels to England, France, Belgium, Holland, Germany, Switzerland and Italy. Following the talk, Dr. Patterson showed movies of the trip.

MARGARET PEEPLES, Columbus, urged that a mental hygiene clinic be formed, and that improvements be made in transportation for medical care, in her talk to the members of the Rosemont (Columbus) P.-T.A. Dr. Peeples stressed that the Muscogee County Board of Education had already done much to improve the environment of schools to benefit the children, but that several more facilities were needed.

Dr. and Mrs. R. C. PENDERGRASS, Americus, attended the Georgia and Florida Radiological Society meeting in Ponte Vedra.

RAYMOND W. PICKERING, Augusta, has returned to the Medical College of Georgia as Assistant Professor of Pharmacology after completing an internship at De Paul Hospital, Norfolk, Virginia.

ROY W. RAY, JR., Alma, formerly of Atlanta, has recently opened offices in Adel for the practice of medicine.

At the 40th Annual meeting of the Radiological Society of North America held in Los Angeles in December 1954, ALBERT A. RAYLE, JR., BRIT B. GAY, JR., of Atlanta, and Jason L. Meadors of Birmingham, presented a paper entitled, "The Myelogram in Avulsion of the Brachial Plexus."

PHIL E. ROBINSON, Albany, was elected chief of staff of the Phoebe Putney Hospital in Albany. Dr. Robinson replaces N. R. THOMAS who tendered his resignation recently, after having served in that office for five years. Also elected to serve this year were BERRY BOWNAM, vice chief of staff and JOSEPH BERG, secretary of staff.

J. ROY ROWLAND, JR., Dublin, became associated with JOHN A. BELL on December 1, 1954, in the practice of general medicine and surgery in Dublin. A 1952 graduate of the Medical College of Georgia, Dr. Rowland completed two years of internship and residency training at the Macon Hospital. He practiced in Swainsboro for five months before moving to Dublin in early December.

Dr. and Mrs. C. J. SAPP, Rome, recently entertained a group of physicians and their wives who have recently come to Rome for residence. Those included were: EVELYN STEVENSON, JACK WALDROP and Mrs. Waldrop, LUCIUS SMITH and Mrs. Smith, CRAWFORD BROCK and Mrs. Brock, and LESTER MARTENS and Mrs. Martens.

HIRAM F. SHARPLEY, JR., Savannah, has been elected chief of staff of the Telfair Hospital.

W. E. SIMMONS, Metter, has been selected by Metter physicians to be chief of staff of the Candler County Hospital. At the recent organizational meeting, J. L. NEVIL was named to submit proposed by-laws to govern the group of local medical people. Local doctors who make up the organization are W. E. SIMMONS, J. L. NEVIL, KATHERINE LOVETT, G. W. MYERS and FRANK LOVETT. Candler Hospital opened on December 1, 1954, having recently been purchased by the county from the estate of R. L. KENNEDY. The hospital was formerly called Kennedy Memorial Hospital.

The Tri-County Hospital, Ft. Oglethorpe, serving Walker, Dade and Catoosa Counties, completed its first year of operation in November. The following physicians were elected to serve during the year 1955: FRED H. SIMONTON, Chickamauga, chief of staff; GEORGE C. VASSEY, Rossville, assistant chief of staff; T. A. COCHRAN, Ringgold, secretary-treasurer.

C. CONRAD SMITH, Augusta, attended the recent meeting of the American Academy of Dermatology in Chicago. Dr. Smith is a Fellow of the Academy.

RAY SPANJER and DON SCHMIDT, Cedartown, were featured speakers at a recent meeting of College Street Grammar School P.-T.A. in Cedartown. Their subject was, "Doctors Talk It Over: TV, Comics, and Movies."

A. GEORGE THURMOND, Augusta, announces the removal of his office to 1345 Greene Street, Augusta, for the practice of obstetrics and gynecology.

E. Y. WALKER, Milledgeville, and Mrs. Walker attended the meeting of the American College of Surgeons held in Atlantic City in November.

JAMES REUBEN WALLIS, Lovejoy, recently had the morning service at the Lovejoy Methodist Church dedicated to him. Dr. Wallis has practiced in Lovejoy for 51 years: a graduate of the Atlanta College of Physicians and Surgeons in 1903, Dr. Wallis also graduated from the Atlanta School of Pharmacy in 1910. On the day of the dedication of the church services to him, Dr. Wallis was the inspiration for a feature article in the *Atlanta Journal and Constitution* Sunday paper.

J. CALVIN WEAVER, Atlanta, has been accepted to active membership in the New York Academy of Sciences.

DAN H. WILLOUGHBY, Savannah, has opened offices in the Deen Building in Hinesville for the practice of medicine. It is understood that he will be in this office on Tuesdays and Fridays of each week. Dr. Willoughby is associated in practice in Savannah with ELLISON R. COOK, III, at 513 Whitaker Street.

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1955 by the Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; 1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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COVER

Cover scene is typical of teaching departments of radiology—a group of medical students listening to the radiologist interpret films.

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(This list can be no more correct than your county secretary makes it. Ed.)

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the executive secretary's letter

State Legislation

Only three of the 200 or more state legislators participating in the 40-day session of the General Assembly were physicians, yet the MAG received more support on medical bills than it has ever had at any one meeting of the legislature. As this issue of the *Journal* went to press, at least one bill—the midwife bill—sponsored by the MAG had been passed by both the House and the Senate and several other bills of medical interest were making progress in both houses.

Midwife Bill

The midwife bill which will require training and registration of midwives received strong support in both houses after it was introduced in the House by Drs. Grady Coker and Marcus Mashburn. Dr. Coker of Canton served as chairman of the Appropriations Committee in the House and Dr. Mashburn, of Forsyth, was chairman of the Hygiene and Sanitation Committee during the recent session. Dr. C. L. Ayers, of Toccoa, was chairman of the Public Health Committee in the Senate.

Other Bills

Drs. Coker and Mashburn also introduced a bill that would allow counties to levy taxes to provide for care of the indigent sick; a bill that would provide for compulsory inoculation against rabies in certain circumstances, and a bill that would allow an alien to receive a temporary license to practice in the two medical colleges in Georgia.

The MAG at the direction of the Committee on Legislation lent its support to several other bills of related medical interest, and the MAG also opposed two bills that were introduced. The committee met several times during the session to discuss these bills.

Plans for the Future

As has been so often pointed out, M.D.'s are often too late with too little when it comes to matters unrelated to their practice. We made considerable progress in liaison with the lawmakers this year, but we can aim for even better cooperation at the next session in January of 1956. The MAG should be a positive force in maintaining the high health standards of the state and in keeping unqualified and undesirable practition-

ers of any branch of the healing arts from locating in the state.

Insurance Board

A two day MAG Insurance Board meeting was held recently. This meeting was an extremely long session concerning proposed revisions of the Georgia Plan of Prepaid Medical Insurance and a report from the Board Subcommittee investigating Professional Liability (Malpractice) Insurance. Meeting with the Insurance Board on Georgia Plan problems were members of the Health Insurance Council representing the insurance industry. Also meeting with members of the Insurance Board were representatives of the insurance firms presently underwriting Professional Liability (Malpractice) Insurance in Georgia. Association policy in these two was recommended and will be presented to the House of Delegates at the May session.

Committee Reorganization

MAG Public Health Committee recently met and approved a change in the structure of the committee. Committee members proposed that the membership of the Public Health Committee be composed of other MAG committee chairmen whose committee work is in the broad field of public health. This reorganization as proposed was transmitted to the MAG Constitution and By-Laws Committee for their consideration (see The Association section of this issue). Advantage of this plan is a closer liaison of MAG committees through a central "clearing house" to be called the Public Health Committee. The plan leaves the other committees involved autonomous, but precludes unnecessary duplication of activity.

MAG Envoys

Representatives of the Association have attended a number of meetings in the past several weeks in order to keep us in touch with medical affairs on a national level. J. L. Chandler of Augusta and Edgar Woody, Jr. of Atlanta attended the recent AMEF meeting at AMA headquarters in Chicago. A report of this meeting will be published in an early issue of the *Journal*. Dr. Chandler is chairman of the MAG Committee on AMEF and Dr. Woody is editor of the *Journal*.

Duncan Shepard of Atlanta represented the Association at the annual Congress on Industrial Health held in Washington. Hartwell Joiner of Gainesville attended an AMA-sponsored meeting on Veterans Affairs in Chicago and George Nicholson of Cornelia, Chairman of the MAG Committee on Rural Health, attended the 10th National Conference on Rural Health in Milwaukee, Wis. David Henry Poer, Secretary-treasurer, attended the 51st Annual Congress on Medical Education and Licensure.

Annual Session

Plans for the 105th Annual Session in Augusta, May 1-4, at the Bon Air Hotel are nearing completion. Approximately 45 commercial booths have been sold and the final scientific program is on its way to the printer. The Woman's Auxiliary Program has also been completed. The program together with information about Augusta and the Annual Session will appear in the March issue of the *Journal*. If you have not already made your plans to attend this important meeting write at once to: Dr. David R. Thomas, Chairman, Hotel Reservations Committee, Bon Air Hotel, Augusta. All meetings will be held in the Bon Air Hotel.

Dates to Remember

Council will meet probably in March in Augusta at the invitation of President Peter B.

Wright. The exact date will be announced later. This will be the last meeting of the Council before the Annual Session and a review of the Association's activity during the past year, will be made . . . The Rural Health Committee will meet on Sunday, March 6 in Macon . . . The Georgia EENT Society will meet at the General Oglethorpe in Savannah on March 11th and 12th . . . The Second District Medical Society will meet at 3:30 p.m., April 7 at the American Legion Home, Camilla . . . The Seventh District Medical Society will meet April 6 at 2 p.m. at the Coosa Country Club, Rome . . . The Ninth District Medical Society will meet at 2:30 p.m. in Toccoa.

Annual Committee Reports

Not fiction to all MAG committee chairmen concerning their annual reports-of-progress for 1954-55 have been mailed. These reports, giving a detailed record of committee activity with recommendations, are then given the House of Delegates for action. Deadline for these reports is March 15. All committee chairmen are requested to submit these reports for their inclusion in the House of Delegates Handbook which is the first order of business for this legislative body at the May 1-4 Annual Session, Augusta.

John F. Kiser
Asst. Executive Secretary

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Name: _____

Address: _____

County Society: _____

1955 A.M.A. Dues	\$25.00
1955 M.A.G. Dues	\$25.00
1955 County Society Dues.....	\$
Total	\$

Make Check payable to your County Society Secretary and remit directly to him now, if you have not already done so.



OPTIMISM IN PROGNOSIS OF PATIENTS WITH MYOCARDIAL INFARCTION

THE STEEPLY RISING INCIDENCE of cardiac infarction evokes a curious combination of alarm and solace. No one can look complacently at figures which state that from 1930 to 1946 the crude death rate from coronary artery disease increased from 7.9 to 95.2 per 100,000, and yet one's apprehension is somewhat mollified by the realization that the reported increase may after all be more apparent than real and that the outlook for the stricken patient is not necessarily dark. It may very well be that the incidence of coronary atherosclerosis is actually increasing, but the mere fact that deaths attributable to this lesion are being reported in greater numbers than ever before does not prove the point. While the late Dr. James B. Herrick of Chicago is commonly credited with having first described the picture of acute coronary insufficiency with myocardial necrosis in 1912, pathologists have known of it for years. Indeed, in the first (1892) edition of his textbook of medicine Osler says, "Complete obliteration of one coronary artery, if produced suddenly, is usually fatal. When induced slowly, either by arterio-sclerosis at the orifice of the artery at the root of the aorta or by an obliterating endarteritis in the course of the vessel, the circulation may be carried on through the other vessel. Sudden death is not uncommon, owing to thrombosis of a vessel which has become narrowed by sclerosis . . ." So the lesson has long been there for all to read, and death from "acute indigestion" is fortunately a vanishing phenomenon.

There are many reasons why physicians are recognizing and reporting more deaths from this form of heart disease than ever before: our aging population, the growth of electrocardiography and the increasing use of hospital beds are some of the more obvious ones. It is difficult for even a statistician to deal with more than one variable at a time. For example, the death rate from cardiac infarction could grow in the face of a stationary incidence of coronary atheroma if this complex

civilization of ours were increasing our thrombophilic tendencies or the metabolic requirements of our heart muscle. Certainly those who regard our present environment as stressful have little difficulty in believing that both mechanisms may be operating.

In any event, whether the statistics are valid or not, it is increasingly obvious that today's physician is entitled to a larger measure of prognostic optimism than he has had in the past. Again, of course figures can be faithless friends and Drs. Hollis and Logue¹ have recently published in this journal a thoughtful and nicely-reasoned analysis of mortality rates with and without anticoagulant therapy which shows how difficult it is to decide what the overall fatality rate from myocardial infarction really is. There is no dearth of pertinent literature of course, but interpretation is difficult because the series are usually small, the controls questionable and the follow-up periods brief. Recently, however, a valuable study has issued from the Michael Reese Hospital of Chicago² which should comfort the afflicted. The report deals with 285 patients who had their initial infarcts between 1932 and 1942 so that even the most recent victims had been followed for 13 years. During this decade an additional 105 patients died within two months of their initial attacks so that the total immediate mortality among 461 patients was 23 per cent. Of the remainder, however, over two-thirds lived more than five years, 44 per cent more than 10 years and 10 per cent more than 15 years. The average survival time was eight years. An even more optimistic communication has recently issued from New York in which Master³ and his colleagues conducted a follow-up study of 500 patients who had survived a coronary occlusion for from one to 29 years; 40 per cent of these patients had had a complete functional recovery, and an additional number experienced only mild symptoms on exertion. Over half the patients had already lived more than five years after the attack and 20 per cent had survived for more than 10 years. These authors urge that such patients return to work at the earliest possible date and state that subjective symptoms are much more important than



EDITORIALS

x-ray or electrocardiographic data. They feel that the outlook for patients who return to work is at least as good as it is for those who retire.

While serious, therefore, the picture could be much worse. Prognostication for the individual patient, however, is a more difficult problem and the wise physician will refrain from a definite commitment during the first two weeks of convalescence at least. Nearly all observers have agreed that congestive failure, thromboembolism, abnormal rhythms and shock are ominous features. Dr. Katz's group found that old age had only a slightly adverse effect on the mortality rate and that males had a slightly better outlook than females, but this latter finding may have been because, as other series have shown, menstruating females seem relatively immune. Neither diabetes nor hypertension exerted any significant influence upon the immediate fatality rate but only 25 per cent of those who survived 10 years were hypertensive as compared with a 45 per cent incidence of hypertension in the entire group. About 60 per cent of the group had had angina before the first infarction, and this also had no obvious effect upon the immediate outcome, but it was interesting that those who had had angina for more than a year lived longer, presumably because of a better collateral circulation. If the infarction occurred at rest, the outlook was poorer than if it happened in association with exercise, possibly because those with the most advanced coronary disease were able to exert themselves the least. Finally, the electrocardiogram was not very helpful as a prognostic tool although patients with atypical infarction patterns or involvement of the septum did poorly. The commonest causes of ultimate death were congestive failure and more infarction.

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VIDECLINIC

FOR THOSE OF US who have wondered about the future of television, any doubts were thoroughly dispelled by the recent closed circuit "Vide-

clinic" which was viewed in 31 cities across the country. This milestone in medical education was presented jointly by the American Medical Association and the local county medical societies in principal cities throughout the country. Smith, Kline & French Laboratories are to be congratulated on the production and sponsorship of such a worthwhile effort. More than 20,000 doctors over the country viewed this experimental telecast and 400 physicians from the Atlanta area were privileged to see this presentation.

It is encouraging to note that the American Academy of General Practice is sponsoring another closed circuit television symposium on February 24th. This time 58 cities will carry the program. With such rapid expansion of facilities, it is not difficult to foresee, in the near future, as many as 100 cities included in these symposia. There is no reason why films of such conferences could not ultimately be made available and distributed to those county medical societies where closed circuit television facilities are not yet available.

No longer need physicians be near a medical center to keep informed on current medical concepts. Television has definitely come of age.

IDENTIFICATION OF X-RAY FILMS

NOT TOO UNCOMMONLY x-ray films made in doctors' offices, clinics and hospital departments bear inadequate identifying data or no identifying data at all. Every x-ray film should show as a minimum an x-ray number or the name of the patient (or both); the date on which the film was made; the name and address of the doctor, clinic or hospital, and an "R" or "L" marker to designate the right or left side of the patient. It is desirable for all films to bear also the initials of the technician making the films.

Identification data can be placed on the film in one of several ways. It can be imprinted on the film at the time of its exposure by the use of lead numbers and letters. It can be flashed on the film in the dark room, using a photographic film identification unit and a card bearing the proper data. It can be written on the exposed dry film with some permanent type of ink (preferably white) or on the unexposed film before development, using an ink pencil. Any x-ray equipment dealer can supply complete information regarding these methods and materials with which to do them.



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Identifying marks on films serve many useful purposes:

(1) They prevent a mixup of patient's films.
(2) The correct diagnosis and treatment in a given case may hinge on one's knowing the proper sequence in which a series of x-ray examinations were made; without proper dating and other identifying marks, such a series may be misleading or worthless.

(3) X-ray films are commonly offered as evidence in medical-legal actions; films bearing incomplete identification or no identification at all may be challenged or disallowed by the court, even though they may be extremely important to the case.

(4) Poorly marked films which are referred along with a patient to another doctor or clinic—a common practice today—may never find their way back to the original owner if identification is lacking.

A.M.E.F.,

FACTS TO PONDER

OUR MEDICAL SCHOOLS are the foundation of America's health. Eighty schools train approximately 27,000 undergraduates and 55,000 other medical scientists taking postgraduate work. They graduate more than 6,000 doctors annually, 1,000 more than a decade ago, but not enough to keep pace with the ever increasing demand. Strong, self-reliant, well-staffed medical schools are a keystone of national welfare. We cannot afford to allow their academic standards to deteriorate; the consequences in terms of national health would be tragic.

The medical schools need an additional 10 million dollars annually to meet their operating needs. Today, at least five million dollars is re-

quired to meet urgent medical school needs and another five million dollars is needed to overcome equally pressing long range problems. Lack of funds is endangering the nation's medical standards. The schools cannot properly maintain their teaching programs. Financial needs of medical schools cause heavy drain upon university budgets, adversely affecting other fields of higher education. On the average, the medical schools take 30 per cent of total university budgets; yet their enrollment is only 10 per cent of the total. Many university trustees are wondering if they can afford their medical schools. Retrenchments have been made wherever possible. Some schools have reduced teaching staffs to dangerous levels. In June 1952 one in 20 full time teaching positions were unfilled. Three private schools, two in New York and one in Texas, have merged with tax supported state universities. Tuitions have been raised as high as is practical. Outside help must be provided at once.

Medical training is by far the most expensive field of education. The rapid increase in medical training costs have been staggering. The average cost of training a doctor has doubled in 20 years to \$10,000. Tuition fees, raised 165 per cent since 1940, pay only one-fifth of this cost. Many factors beside inflation contribute to increased costs: the lengthy training period, costly laboratory facilities, high ratio of teachers to students and complicated training technics arising from recent scientific advances.

Gifts, income from endowment, general university funds and public appropriations no longer provide sufficient revenue to meet current operating costs, let alone future demands. Endowment income has shrunk, capital gifts for teaching purposes have been few, general university funds have been tapped to the hilt. Funds from other sources must be found before irreparable harm is done. The funds must either come from government or private sources, the latter is preferable. AMEF provides a workable solution. The matter lies squarely in our hands.

Attend Your Annual Session

BON AIR HOTEL, AUGUSTA, MAY 1-4, 1955



REVIEWS

LECTURES ON GENERAL PATHOLOGY. Edited by Sir Howard Florey, Professor of Pathology, Sir William Dunn School of Pathology, University of Oxford. W. B. Saunders Company, Philadelphia and London, 1954, 733 pages, illustrated \$13.00.

This is a series of lectures taken from a course in general pathology and bacteriology at the University of Oxford. The book includes a variety of topics in which the authors are particularly interested, and it is not intended to afford a complete survey of general pathology. There are relatively short discussions of a number of subjects, including degenerative and regenerative tissue changes, of the blood as a tissue, of circulatory disorders and the reactions of the body as a whole; there is a very extensive consideration of the mechanisms of immunology and allergy with correlated chapters on the pathogenicity and virulence of microorganisms. The historical development of current concepts is often outlined, with brief descriptions of experimental techniques. Little of the usual detail of microscopic changes in disease is included, but the primary emphasis is rather placed on the physiopathology of the changes that occur in the body in response to noxious stimuli. This approach is deliberate on the part of the authors, as it is their expressed intention to stimulate in their students an experimental outlook in clinical studies.

The arrangement and limited scope of the book preclude its use as a text, but it should prove of interest to lecturers and students in pathology, bacteriology and immunology, as well as to the general reader who wishes to review some of the basic mechanisms of disease. The material for the most part is very readable, and the bibliography is excellent. The illustrations and typography are very good.

William McCollum, M.D.

Welch, Henry, Ph.D., A Manual of Antibiotics, 1954-1955, Medical Encyclopedia, Inc., New York, 1954, 87 pages, \$2.50.

This manual lists the commercially available antibiotic preparations for both human and veterinary use. The products are tabulated alphabetically by their generic terms with the trade name given by the manufacturer also listed for each antibiotic. The general indications for use of each antibiotic are included. Separate indices for the generic name, the trade name and the manufacturers' name and address serve for ready reference.

This manual should prove equally valuable to

the physician and the pharmacist as a reference book in understanding of the increasingly complex nomenclature in this field. Moreover, the listing of the amount of each antibiotic present in the various commercially available combinations should be of value in the selection of such preparations for clinical use. Periodic revision of this book is planned in order to keep abreast of the field.

Charles LeMaistre, M.D.

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Treatment of Uncomplicated Myocardial infarction

JOHN F. STEGEMAN, M.D., Athens, Ga.

THERE IS OFTEN a tendency to treat common diseases after a standard pattern, with little variation in routine orders. This temptation may lead to unfortunate results in the management of myocardial infarction, for there is no disease in medicine in which it is more important to consider each illness on its own merits. A slight infarction may bear no clinical resemblance to a massive one, and the two types need not be treated in the same manner.

Today, there is evident a much more conservative attitude regarding relatively minor myocardial infarction. It is now generally felt that the slight and uncomplicated attack can be managed without such standbys as oxygen, anticoagulants and private nurses. Indeed, adequate treatment at home, with a minimum of visits by the doctor, is entirely possible. Recent mortality statistics are far more encouraging than in former times, and an air of optimism on the part of the physician is entirely justified. Such an attitude should not be hidden from the patient, who often absorbs the pessimism of anxious friends and relatives. Oversolicitousness and overtreatment are psychological hazards that impede recovery by nurturing cardiac neuroses.

On the other hand, if the infarction is of major degree, the closest attention to detail is imperative, and provisions for the patient's rest and comfort become as essential as more specific measures. Depriving such a patient of his vital sleep to satisfy hospital routines is pure folly. Such practices as taking temperatures or giving baths in the early morning, or rousing patients for non-essential medications during the night, should be strictly

forbidden. The physician should give specific instructions as to bathing, shaving, feeding, propping up or turning the patient, and he should assume complete responsibility in the designation and regulation of visitors. Around-the-clock special nurses are often essential in such cases and always make the doctor's task easier.

Prompt relief of pain is of primary importance. It is not enough to leave an order for an opiate "every four hours," but it should be the duty of the physician to see that pain is allviated before he leaves the bedside. Intravenous narcotics, while carrying some hazard, are sometimes necessary. Allaying apprehension by the use of barbitals is another important consideration, and skillful use of these drugs may diminish the amount of narcotic required.

Oxygen should be used in all infarctions whenever there is evidence of shock or other signs of circulatory embarrassment. Whether it is to be administered by mask, nasal tube or tent is an individual consideration.

Anticoagulant therapy should never be denied in major attacks unless a specific contraindication is present. Intravenous administration of sodium heparin in doses of 50 to 100 milligrams every four to six hours, so as to keep the clotting time prolonged to around 20 minutes, is a common method of reducing embolic complications. Dicoumarol, given orally in doses sufficient to keep the prothrombin time between 20 and 30 per cent of normal, is equally beneficial but requires two or three days to reach an effective level. It has become popular to use heparin and dicoumarol during this lag period. Anticoagulants

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.

should be continued for a minimum of two weeks upward to many weeks, depending on the severity of the illness.

The prophylactic use of quinidine in the treatment of ventricular arrhythmias is favored by many and will be discussed on the Heart Page when the subject of complicated infarctions is presented.

Bed rest should be continued for a variable length of time, depending on severity, but three weeks is the usual minimum. How "absolute" the rest should be depends on the gravity of the illness. Doctors usually concede the use of a bedside

commode, for example, in all but the most unfavorable cases.

Diet during the acute illness is of little importance qualitatively, but the caloric intake should be low, and the nourishment easily digestible. Liquids are often best tolerated in the first few days. The use of low-fat, low-cholesterol diets is a controversial subject.

Other long-range considerations must be dealt with by the doctor once convalescence begins, but the ultimate goal should always be the early, yet safe, return of the patient to a status of self-sufficiency.

Heart Institute Welcomes Referrals

The National Heart Institute, in Bethesda, Maryland, as a part of its research program, would welcome referrals from Georgia physicians of difficult cardiac or metabolic patients. This facility should prove very attractive to indigent or semi-indigent patients, as all expenses of hospitalization and patient care are borne by the Institute. The patient's only expense would be transportation to and from Bethesda.

The following is a list of some of the disorders in which the Institute is currently interested:

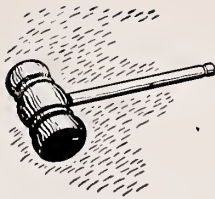
- (1) Paroxysmal tachycardia, frequent and prolonged
- (2) Pheochromocytoma
- (3) Paroxysmal auricular fibrillation
- (4) Intermittent bundle branch block
- (5) Selected cases of hypertension
- (6) Glomerulonephritis
- (7) Nephrosis
- (8) Hypercholesterolemia
- (9) Addison's disease

- (10) Parathyroid disease
- (11) Panhyperpituitarism
- (12) Diabetes insipidus
- (13) Acquired heart disease, especially rheumatic with mitral stenosis and/or insufficiency
- (14) Congenital heart disease, especially where shunts are suspected
- (15) Occlusions of major portions of the arterial system
- (16) Esophageal varices
- (17) Aortic aneurysms

A physician who wishes to consider referring a case will save considerable time if he includes a complete abstract at the time of his initial inquiry. The Institute will then promptly place him in touch with the investigator who will act as the responsible physician during the patient's stay at Bethesda.

Send all inquiries to: National Heart Institute, National Institutes of Health, Bethesda 14, Maryland.

Make your hotel reservations now
for the 105th Annual Session
of the Medical Association of Georgia—see page 86



president's page

"Every man who is high up loves to think he has done it all himself; and the wife smiles, and lets it go at that. It's only our joke. Every woman knows that."

This year, 1955, the members of the Woman's Auxiliary to the Medical Association of Georgia will observe the Auxiliary's thirtieth anniversary! Nearly a third of a century of devoted service to their husbands' association, giving wholeheartedly everything they had, to assist in the progress of medicine.

Little has been said of them and their efforts, even less prominently have their achievements been publicized. However, our interests and problems have been under serious consideration by them, and they have strived most sincerely to help in anyway possible.

Is it not fitting and timely for the Medical Association of Georgia, as a group and as individuals, to pause and realize the value of the Auxiliary and thankfully appreciate their indispensable endeavors and accomplishments, their never ending ambition for us?

Not until I became president-elect did I know just what the Auxiliary means to the MAG. At that time Mrs. Ralph Fowler, then president of the Auxiliary, by her activity in the Association, and later the work of Mrs. Leo Smith, caused me to realize the Auxiliary's value. This made me more appreciative of our most precious possession—the women. Voluntarily, I pledged my support to the Auxiliary and to Mrs. Shelley Davis, who is serving, most admirably, her presidency in that phase of our organization while I am serving as president of the M. A. G. When our terms are over, I have every confidence that Dr. H. Dawson Allen, as president of the M. A. G., and Mrs. Robert Major as president of the Auxiliary, will continue to work "shoulder to shoulder" for the good of medicine and our Association as have our predecessors.

As was said of Florence Nightingale, "When all the medical officers have retired for the night, and silence and darkness have settled down upon those miles of prostrate sick, she may be observed alone, with a little lamp in her hand, making her solitary rounds"; We may apply that to our ever faithful Woman's Auxiliary. God bless them, and thank God for them.



Advanced Cancer

ROBERT L. BROWN, M.D., Emory University, Ga.

THE MANNER AND attitude of the physician who is directly concerned with the management of the patient who has advanced cancer are very important. Just because the disease is incurable does not mean that nothing can be done. There is almost always something that can be done to help the patient in some way. The physician should have his patient's interest at heart and the patient should feel this. It is essential that we do not let him down. In a situation of this kind when it may not be possible to do big things, little things assume greater relative importance, and they certainly are appreciated by the patient out of all proportion to their magnitude.

In order to help the patient meet his problem, it is important that he have some understanding of his illness. This brings up the age-old question as to what the patient should be told. Far older than "the truth, the whole truth and nothing but the truth," is the precept as old as medicine itself, "Do no harm." The patient should be told that part of the truth which will help him. This means, of course, that there can be no fixed rule which will apply to all patients and that the insight and understanding of the physician and the problems of each individual patient determine just what shall be said. The truth can be cold and cruel or gentle and merciful according to the manner of the informer. Many patients do not ask for specific information probably because they do not want to have their fears confirmed. As time goes on a tacit understanding practically always develops between the physician and his patient, and one cannot help but feel that it is perhaps better if some things are left unsaid. When the patient finally realizes that he is not going to get well he

is usually so worn out and tired that he does not greatly care. It is essential of course that the patient understand that his illness may be prolonged and that he cannot definitely count on returning to work. This will help him in making such financial adjustments as he may need to make for his business interests and his family.

Epictetus many centuries ago said, "Every vessel has two handles, one by which it may be borne and one by which it may not be borne." We should try to help the patient take hold of his illness so that it may be borne. This is not easy, but there is usually some way to bring it about. Sometimes centering his interest on the past rather than on the future is helpful. Pointing out that even though he is ill it is possible for him to be at home with his family is consoling. Sometimes, if he is in the terminal stage of his illness, just the realization that everything that can be done for his comfort is being done makes the situation bearable for him.

Osler, as you may recall, advocated "life in day tight compartments." With a limited period of life due to the presence of incurable cancer, each day becomes of much greater importance to the patient, and anything we can do to fill each day with the things that he most wants to do and which will be the most rewarding for him will be helpful. If he can be led to realize that life is uncertain for all of us and that after all today is the most important time since none of us knows with certainty about tomorrow, he can maintain an interest in life on a day-to-day basis which he might lose if he looked ahead to a dark future. Many patients, as a matter of fact most people and especially women, tend to want to cross bridges before they get to them. We should do

all we can to help patients with cancer avoid this very potent cause for worry and concern. Many times they anticipate that they are going to have far more discomfort than they actually will have, or that things will happen which may actually never occur. Anything that we can do to get the patient's interest centered on something other than himself and his illness will be definitely beneficial.

There are a number of measures which do not call for the use of drugs for relief of pain, which are of great value in the management of the patient with incurable cancer. They approach the problem in other ways. Hormone therapy, for example, is a palliative measure which will at times result in a diminution of pain and an increase in appetite and sense of well being. In advanced cancer of the breast in women before menopause, testosterone is the best hormone preparation to use. In elderly women with cancer of the breast, stilbestrol may occasionally bring about improvement. In cancer of the prostate stilbestrol is often very valuable. X-ray therapy may prove to be of value in the relief of pain especially when metastatic cancer involves bone. In some cases of cancer of the thyroid, radioactive iodine has been beneficial. Neurosurgical measures for relief of pain can sometimes be helpful in the management of patients with advanced cancer. When the disease is unilateral and the pain is unilateral, a cordotomy can give marked relief and is certainly worthwhile if the life expectancy is more than a few months.

Cleanliness is of great importance especially when ulcerated lesions are present. Cheerful surroundings make a very appreciable difference in the way that a patient feels. Attention should be given to intake of food and fluid and efforts made to keep it adequate.

A patient with advanced cancer will probably live longer than you expect him to and will do better if he does not receive any more pain relieving medication than he really needs. The severity of pain is not in direct relation to the extent of the disease. Many times patients with very advanced, incurable cancer have relatively little pain. Aspirin, empirin and phenobarbital should be used as long as they are effective. Empirin Compound No. 3 has been our most valuable single drug for the control of discomfort in people with advanced cancer. This has remained effective over many months and only when it is no longer helpful need demoral, morphine, levodroman, dolophine or similar compounds be consid-

ered. It is advisable to avoid dependence on hypodermic injections as long as possible.

Drug addiction is not often a problem because of the limited duration of life in advanced cancer, but over-sedation may be a problem. It is certainly true that patients can feel bad because of having too much medication, and they will feel better when the dosage is reduced to the lowest level essential for a reasonable degree of comfort. The ideal of a completely comfortable patient is seldom realized, but if the patient can be made to understand that even though he may have some discomfort, measures will be taken to keep it from being severe, the situation usually works out fairly satisfactorily. If the patient feels that he should not experience any discomfort at all, he will be calling for medication at times when it is not really necessary.

Another question which arises concerns what should be told the family. Responsible members of the family should be fully informed about the patient's disease and its probable outcome. Sick people are sensitive to the atmosphere about them, and the family should be encouraged to adopt a hopeful, optimistic attitude while with the patient. It is still necessary in many instances to relieve their fears regarding contagion. It is probably best not to predict the length of the patient's life since you will probably be wrong. General terms such as "weeks rather than months" or "months rather than years" are best.

Summary

1. By our manner and attitude we should convince the patient we are going to help him in every way we can and that we will not neglect him or let him down. We should not forget the real value of palliation. The care of the incurable cancer patient is often trying and difficult, but the physician's efforts are appreciated by the patient and his family out of all proportion to what one is actually able to accomplish.

2. We should try to help him adjust to his disease and to the marked changes in his life plan which his illness has brought about.

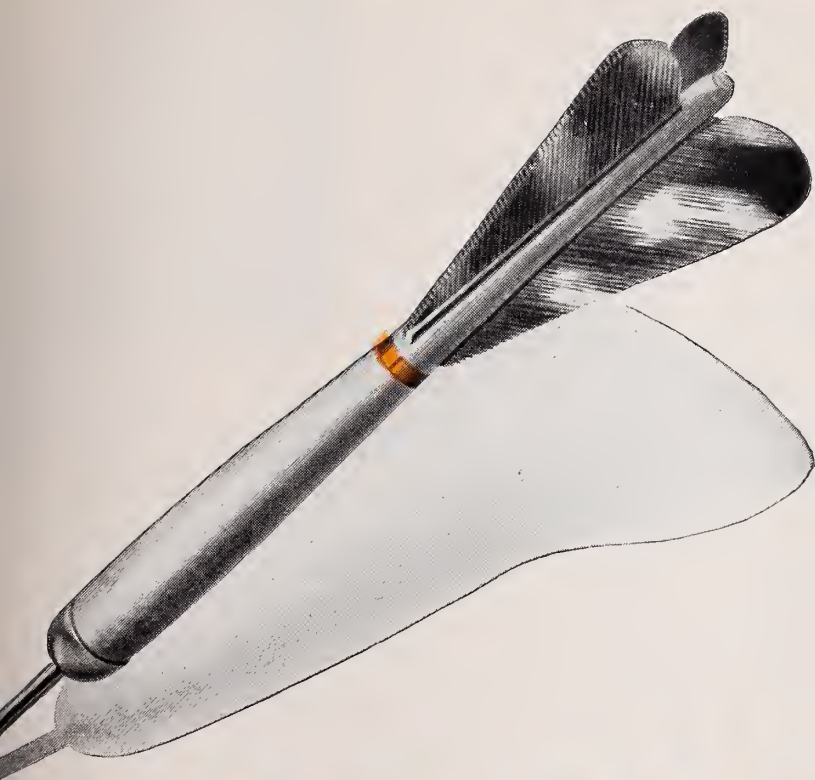
3. We should do all that we can to relieve his discomfort and should remember that measures other than heavy sedation may prove to be of very real value.

4. In incurable cancer, as in all of medicine, the secret of patient care lies in caring for the patient.

5. We should be constantly aware that the duty of the physician is to cure sometimes, to relieve often, to comfort and support always.

The background features a series of concentric, thick black rings on a light gray, textured surface that resembles concrete or stone. The rings are centered on the right side of the image, creating a sense of depth and movement. The overall aesthetic is modern and industrial.

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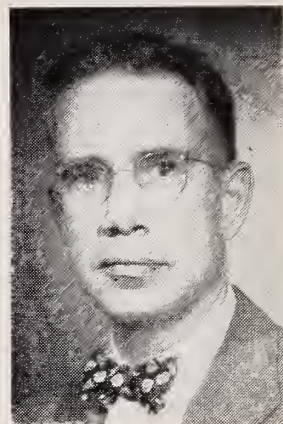


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The Diagnosis and Management of Congenital Heart Disease

NELSON K. ORDWAY, M.D., Chapel Hill, N. C.



ESSENTIALLY THE only definitely curative or ameliorative management of congenital cardiac anomalies lies in corrective surgery, but I do not propose to discuss surgical techniques with you—indeed, I am not competent to do so. Since successful surgery presupposes accurate preoperative diagnosis, I might dwell at some length on the fancy diagnostic procedures that are carried out in numerous centers. I propose, however, to emphasize chiefly those diagnostic skills which are shared by all physicians—that is, the complete and careful history and the complete and careful physical examination.

Diagnosis

The appraisal of the child from the cardiac standpoint progresses in logical, orderly fashion, if answers are sought successively to four questions:

1. *Does the child have heart disease or not?*

The most serious erroneous answer to this question is the affirmative one when the heart is perfectly normal. Not infrequently pathological significance is accorded the normal precordial systolic murmur. Worse still, various restrictions are placed on the child's activities, although even if he did have congenital heart disease it would be unwise to restrict him. Most children normally have heart murmurs at some time or other. The normal heart murmur is systolic, appears to be separated from the first sound by a brief pause and abruptly disappears at about mid-systole. It is usually relatively high pitched, sometimes almost musical, frequently crescendo in intensity,

occasionally variable in amplitude according to the phase of respiration and frequently of a quality I can best describe as "squeezing." When loud it suggests various characteristics of the New Year's Eve horn: if one blows with gradually increasing force into this noise-maker there is at first no sound; then there is heard a moderately high pitched sound which becomes constricted and "squeezing" in quality as it gradually increases in intensity; and finally the vibrating reed suddenly comes to rest against the shallot, occluding it to further passage of air and abruptly terminating the sound.

The normal murmur may be heard anywhere over the precordium and is frequently described as either apical or "pulmonary".* It is usually poorly transmitted and is rarely audible in the back.

Another normal murmur, the venous hum heard when the patient is erect, should cause no difficulty, since it is easily obliterated by lightly occluding the jugular vein with the finger, by laying the patient supine, or—curiously enough among murmurs—by having the patient exercise vigorously. It is continuous from systole into diastole, but there is no other resemblance to the continuous murmur of patent ductus arteriosus.

Less frequently than the erroneous diagnosis of non-existent disease, a bona fide congenital cardiovascular anomaly may be missed because of inadequate examination. None of the five most recent cases of coarctation of the aorta I have seen were

Presented at the 104th Annual Session of the Medical Association of Georgia, Macon, May 2-5, 1954 as the Benjamin Bashinski Memorial Lecture.

From the Dept. of Pediatrics, Louisiana State University School of Medicine, and the L.S.U. Pediatric Service, Charity Hospital of Louisiana at New Orleans.

*The latter location is interesting since the normal murmur, which is presumably functional, may be confused with the murmur of atrial septal defect, which is also presumably functional and is most frequently maximal in intensity at the second left interspace. It is likely, however, that the presence of an atrial septal defect of sufficient size to give rise to a murmur would be suggested by enlargement of the heart and pulmonary vessels together with electrocardiographic evidence of right ventricular hypertrophy.

diagnosed by the referring physician. True, in four of these it was recognized that something was wrong with the heart. The fifth, a three year old boy who had undergone several surgical procedures for the repair of cleft palate, was at last diagnosed by a third year medical student, who, in the course of a routine physical examination, noted hypertension in the upper extremities and absence of the femoral arterial pulsations.

Another, rarer condition which can be cured by surgery is a double aortic arch, obstructing trachea and esophagus. This anomaly should be suspected in any infant subject to recurrent bouts of pneumonia, with or without signs of tracheal obstruction. Confirmation of the clinical suspicion is simple with a little iodized oil and a fluoroscope—if one considers the possibility. Marked forward and lateral deviation of the esophagus produced by the constricting ring is easily seen as the infant swallows the radio-opaque substance.

2. *If the patient has congenital heart disease, what is the anatomical diagnosis?* This question is sometimes answered with almost ridiculous ease. Routine physical examination without other information usually permits the diagnosis of coarctation of the aorta, ventricular septal defect and patent ductus arteriosus. In classical ventricular septal defect the diagnosis is obvious as soon as the palpating hand detects a thrill, sharply localized at, or just to the left of, the midline at about the junction of the body of the sternum with the xiphoid. A blowing murmur, systolic in time, is also maximal here; it is usually quite loud and diminishes markedly in intensity as one auscultates at a distance from this point. The rough, continuous murmur of patent ductus arteriosus may be likened to the rhythmic rumble of a concrete mixer in which large rocks periodically tumble to the bottom, quite as an accentuated, split second sound rhythmically punctuates the ductus murmur. The pulse pressure is widened in patency of the ductus arteriosus; this, detected most easily at the femoral artery, is one of the early signs of this anomaly in the infant.

The history alone may suggest the nature of a lesion, though confirmatory observations are necessary, as in the case of the vascular ring just described. In pulmonary valvular stenosis, for instance, if the ventricular septum is intact, the history characteristically reveals that during exercise the patient suddenly becomes unable to continue activity; he stops, breathes fast, sits or lies down and may become pale. If the degree of

pulmonary stenosis is severe and the foramen ovale is open, there may be cyanosis, but the historical facts are otherwise essentially the same. If, on the other hand, there is an associated ventricular septal defect—that is, if the lesion is the tetralogy of Fallot—the response to muscular exercise consists of hyperpnea, cyanosis or increased cyanosis rather than pallor, and the assumption of a squatting rather than a sitting or lying position.

While the anatomical diagnosis may then be easy, more often it is not. A heart murmur may be classical and typical, as the two normal and two pathological murmurs previously described; more frequently, however, a murmur is significant only in that it calls attention to the existence of a congenital cardiac defect. The more I listen to hearts, the more I feel, as did Gertrude Stein about roses, that “a murmur is a murmur is a murmur is a murmur.” For example, a patent ductus arteriosus may exist without a diastolic component to the murmur or without any murmur at all. And atypical features of congenital heart disease are not limited to the physical examination; they may appear in all phases of the clinical appraisal. By way of example, the child with an otherwise typical tetralogy of Fallot may present on radiographic examination an essentially normal cardiac silhouette.

Despite frequent difficulty in arriving at a precise anatomical diagnosis, it is usually possible to place a cardiac lesion in its proper pathophysiological category. For purposes of simplification there are four such categories:

The first, to which I shall refer loosely as “intrinsic myocardial insufficiency,” includes the common lesion, endocardial fibroelastosis, as well as rarer abnormalities such as cardiac glycosinosis. These disorders are by and large limited to infants and young children; they are characterized by progressive cardiac enlargement and failure and consequently retarded growth.

TABLE I	
Medical Treatment of Children With Congenital Heart Disease	
A. All types of heart disease	
1. No restriction of activity	
2. No restriction of activity	
3. Prophylaxis of subacute bacterial endocarditis	
B. Left-to-right shunts	
1. Protection from pulmonary infection	
2. Vigorous treatment of infections	
3. Treatment of heart failure	
C. Right-to-left shunts	
1. Morphine and oxygen for syncopal attacks	
2. Transfusion for anemia	

A second category includes primarily obstructive lesions. Coarctation of the aorta and sub-aortic stenosis are obstructive lesions on the left; isolated pulmonary valvular stenosis and essential pulmonary hypertension, on the right. The features of coarctation are well known. The other obstructive lesions are all similar to one another in that, when severe, they are characterized by reduced exercise tolerance with little or no cyanosis and may lead to cardiac enlargement and failure.

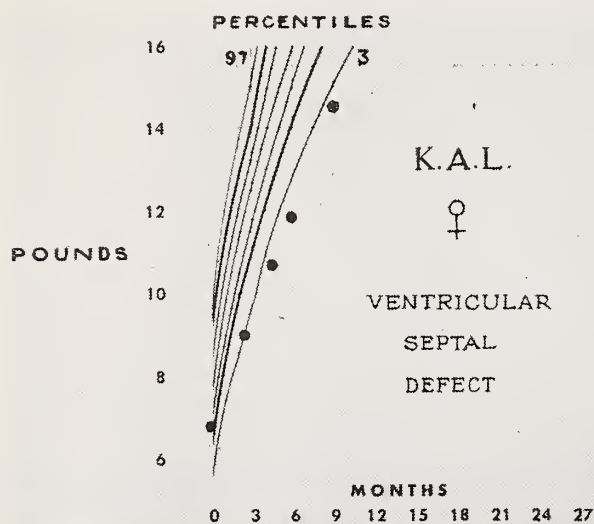


FIGURE 1
Weight gain of infant with large left-to-right shunt*

The third category, that of left-to-right shunts, is a large group composed of atrial, ventricular and aortic septal defects, patent ductus arteriosus and anomalies of pulmonary venous return. The complications to which patients with large left-to-right shunts are subject are easily understood in the light of their altered circulatory dynamics. The basic disturbance in all is the useless shunting of already oxygenated blood back to the pulmonary arterial circulation. The larger the shunt, the greater the pulmonary circulation and the smaller the systemic blood flow. Because of the impoverished blood supply to the body as a whole, growth may be retarded (Fig. 1). In an attempt to direct blood to more vital regions of the body, flow to the skin is reduced, presumably through sympathetic nervous mechanisms, with resulting pallor and increased sweating. Muscular activity is restricted. The heart and pulmonary vessels dilate to accommodate the shunted blood, and a variable degree of pulmonary hypertension re-

sults. If the shunt is large and/or the pulmonary pressure high, heart failure may ensue. The augmented amount of blood in a thorax of relatively constant volume displaces a similar amount of air, with consequent impairment of ventilation for which the patient seeks to compensate by breathing more rapidly. Lower respiratory tract infections are frequent in these patients and are very likely due to inefficient ventilation.

The fourth category is that of right-to-left shunts. This is a heterogeneous group, most of the members of which also have some degree of left-to-right shunt. Its prototype and most frequent representative is the tetralogy of Fallot. In this complex anomaly, part of the right ventricular output is directed into the aorta, with resultant diminution of pulmonary blood flow. The tetralogy of Fallot should not be considered an obstructive type of cardiopathy, since the ventricular septal defect and over-riding aorta permit the right ventricle to expel its contents at a pressure not exceeding that in the left ventricle. Consequently these patients do not have cardiac enlargement or heart failure. If there is sufficient shunting of venous blood into the systemic circulation, the patient is cyanotic. The amount of blood which can pass through the pulmonary valve is relatively constant. Consequently, when the systemic blood flow is increased by muscular exercise, a larger volume of venous blood is shunted into the overriding aorta, with resulting increase in cyanosis. The child may have learned to increase his arterial oxygen saturation by squatting, a maneuver which appears to alter venous return to the heart in a manner as yet incompletely understood. If the arterial saturation falls sufficiently low, the patient may lose consciousness. The hypernea which results reflexly from the lowered arterial oxygen saturation is in itself a moderately severe form of exercise, and may set off a vicious state of cyanosis, dyspnea and syncope, the so-called syncopal attack.

At this point three generalizations will serve to summarize my comments on these four categories of heart disease. While like all generalizations they are over-simplified, they are helpful in the evaluation of the patient.

a. Cardiac enlargement and heart failure signify "intrinsic myocardial insufficiency," obstruction or a large left-to-right shunt.

b. The patient with a large left-to-right shunt has a large heart and pulmonary vessels, exhibits little or no cyanosis and is subject to heart failure.

*That the association between the cardiac lesion and the small body size is one of cause and effect, is of course inferential.

His difficulties are *cardiac* and *circulatory*.

c. The patient with an uncomplicated large right-to-left shunt has a small heart, has diminished pulmonary vascular markings on roentgenologic examination, is cyanotic and is not subject to heart failure. His difficulties are not cardiac and circulatory, but *anoxic*.

In the light of these generalizations, it is clear that any patient who has both marked cyanosis and an enlarged heart or failure must have an additional factor complicating his right-to-left shunt: if his pulmonary flow is *decreased*, he must have an obstructive lesion such as pulmonary valvular stenosis with intact ventricular septum or tricuspid atresia with a small foramen ovale. Such a patient can be helped by surgery. If, on the other hand, his pulmonary blood flow is *increased*, he must have partial or complete transposition of the great vessels, so that his pulmonary and systemic circulations are to a large degree independent of one another. At the moment surgery has little to offer in this type of anomaly.

Once a diagnosis has been made, either specifically or according to pathophysiological category, the third question may be asked:

3. *Does the patient need to be brought to the attention of a pediatric cardiologist?* Otherwise phrased, does the patient need surgery or not? The answer to these questions is the crux of this discussion.

The decision as to the necessity for further evaluation rests on the following clinical observations:

General features. Is the infant irritable and fretful? Are growth and nutrition impaired? Are there repeated lower respiratory tract infections? Is there clubbing of the fingers and toes? Is there cyanosis or pallor? Are there acute episodes of dyspnea or syncope?

Polycythemia is an unfavorable sign, usually suspected clinically from the plethoric appearance of the conjunctivae and malar eminences, and easily confirmed in the laboratory. I have, however, encountered several children with large right-to-left shunts who, presumably because of the depressing effect of anoxia on the bone marrow, were anemic rather than polycythemic. They were susceptible to syncopal attacks which could be prevented by increasing their hemoglobin by means of blood transfusion, a procedure which incidentally increased the intensity of their cyanosis.

Exercise tolerance. What is the limit to which the patient can walk, climb, play games? Is

breathlessness increased by nursing? Does the child squat?

Heart size and activity. Is the heart enlarged? Is the rate elevated? Is cardiac action abnormally forceful? Are the sounds loud? Or are they distant?

Various techniques must be employed in estimating heart size. If the heart is enlarged, the right ventricle, which usually contributes to the enlargement, may constantly beat against the anterior chest wall, thereby causing in a growing child an asymmetrical bulge on the left. The apex beat and area of cardiac dullness are difficult to detect in the infant, so in this age group one relies heavily on x-ray and fluoroscopy for the evaluation of heart size. I look with suspicion on many x-rays of infants' hearts, however, since the cardiac silhouette is frequently distorted by expiration and crying, supine position of the patient, short film distance and anteroposterior projection. The fluoroscopic examination, quite apart from its revelation of cardiac activity, is essential if only to assess the adequacy of the roentgenogram. Evaluation of the overall shape and size of the cardiac shadow is in general more helpful than speculation as to the size of the individual chambers, since our fluoroscopic criteria are to a large extent based on what happens to adult hearts that were once normal—that is, on the changes seen in acquired heart disease. There are, however, a few valid and helpful signs, such as displacement of the barium-filled esophagus in the region of the left atrium and demonstration of a dilated right atrium in the left anterior oblique projection. The electrocardiogram, as interpreted by one familiar with its normal appearance in small patients, is much more reliable than the x-ray in the evaluation of ventricular hypertrophy.

Heart failure. Is the respiratory rate elevated at rest? Does auscultation reveal gallop rhythm? (This is probably of dubious significance.) Is the liver enlarged? Does it pulsate? Is the pulse pressure narrow? Is pulsus paradoxus present?

The most reliable signs of failure in the infant and child are dyspnea and hepatic enlargement. Moist rales in the lungs are not commonly heard. Pulsus paradoxus occurs frequently in children with large left-to-right shunts and is readily detected during the auscultation for blood pressure. As the pressure in the cuff falls, one hears the systolic sound at first during expiration only; then, at a lower pressure, both during expiration and inspiration. The phenomenon is greatly exaggerated in a crying infant.

Systemic circulation. What is the blood pressure? Are arterial pulsations present in the lower extremities? Is a wide pulse pressure shown by sphygmomanometry, palpation of arteries, capillary pulsation or auscultation of a femoral pistol shot? Or, on the other hand, is the pulse pressure narrow, as it may be in subaortic stenosis or heart failure? Does the skin regain its color slowly when momentarily blanched by the stethoscope bell or the examiner's fingers? Is excessive sweating, particularly of the head, recorded in the history and noted during the physical examination when the baby nurses or cries? Does the skin of the palms and soles have the satiny texture characteristic of patients with severe impoverishment of the systemic circulation, and resembling the similar trophic disturbance in rheumatoid arthritis?

The "flush" method of taking systolic blood pressure is frequently of help in infants, particularly when coarctation of the aorta is suspected. A rubber glove, or better still a three-inch rubber bandage, is wrapped around the distal portion of an extremity so as partially to exsanguinate it. A proximally placed sphygmomanometer cuff is then inflated to a pressure above systolic, and the occluding bandage is removed, revealing a blanched area of skin. The pressure in the sphygmomanometer is now reduced in the usual manner. The systolic pressure is that at which reactive hyperemia of the blanched skin suddenly appears.

Pulmonary circulation. Is there pulmonary hypertension, shown by a banging, split second cardiac sound detected by palpation and auscultation of the chest? Does the x-ray show the pulmonary vascular markings to be increased, or are the lungs clear? Do the hilar vessels pulsate at fluoroscopy? The peripheral vessels?

On the basis of the foregoing considerations, one asks the final question:

4. *If further evaluation is indicated, when should it be carried out?* The answer to this question is clear-cut, simple and brief: a) *in the newborn period*, in the case of any infant with persisting cyanosis; b) *at any time*, in the case of any child, with any lesion, who is not doing well. Occasionally there is so much delay before a patient with an operable lesion visits the consultant that irreparable damage or death occurs. There is no optimal age for evaluation or operation. Surgery for tricuspid atresia or pulmonary valvular stenosis may be necessary as an emergency procedure in the newborn period or shortly thereafter. The high operative mortality in young

infants with anomalies such as the tetralogy of Fallot is related not so much to their tender age and small size as to the fact that they have lesions so serious that they would very likely succumb without operation. Just last month a four month old infant with a patent ductus arteriosus and pulmonary hypertension died on our wards with heart failure and pneumonitis. Our surgeons have successfully divided the ductus of a three month old, five and one-half pound, premature infant. They tell me that excision of a coarctation is easier in infancy than in later years, and have successfully performed the operation on a four week old infant in heart failure.

In summary, the child needs attention when it needs attention. To wait for the magic age of six months or two years or six years in the face of clinically evident poor health or downright deterioration is irrational and can be disastrous.

Management

The only specific therapy for children with congenital heart disease is surgery. Surgery is recommended for many children with vascular rings obstructing the trachea and esophagus, valvular stenosis and the tetralogy of Fallot and certain of its analogues. Surgery is recommended for *all* children with uncomplicated patent ductus arteriosus and coarctation of the aorta.

Regardless of the preeminent role of the surgeon, however, children with congenital heart disease still have to be treated by the medical practitioner. The principal features of medical management are summarized in Table I and elaborated in the following paragraphs:

The repetition of the injunction against restriction of activity is not due to editorial oversight, but is designed to focus attention on the most important feature of medical care of these children. Restriction of activity is based on the probably false premise that exercise is bad for the heart. There is only one type of cardiac anomaly in which restriction of activity can be justified on the basis of sound *theoretical* considerations. It is theoretically possible that the child with obstruction such as is present in essential pulmonary hypertension or valvular stenosis may die suddenly of acute cerebral ischemia if he overexerts himself. I used to recommend restricting the activity of such children but soon learned that they didn't pay any attention to the interdiction anyway, and furthermore they didn't get into trouble. So now I allow them the same freedom that I do other children with congenital heart disease. Even if restriction did any good, it would still be unwise to focus

attention on the heart to the exclusion of the child. The challenge to us as physicians is to see that these handicapped children grow up as well adjusted and nearly normal as possible. This cannot be achieved if the mother is instructed not to let the baby cry, or if the older child is repeatedly called in from play and made to rest. The child with heart disease knows better than the physician when to stop—any parent of a child with reduced exercise tolerance can tell us that. Of course, in the case of older children, interdiction of certain competitive school sports may be necessary.

Penicillin should be given to the child with a cardiac abnormality for a day or two before he goes to the dentist, on that day and perhaps for a day afterward. This is recommended since penicillin will reduce the population of alpha-hemolytic streptococci in the mouth and consequently minimize the likelihood of bacteremia and subacute bacterial endocarditis. Even dental prophylaxis should be considered a potentially hazardous procedure. The same precautions, more energetically carried out, apply to surgical operations about the mouth and throat.

Protection of the young cardiac from infections of the lower respiratory tract is to a large extent achieved by restricting his contacts with other people. It is hardly necessary, for instance, to take the baby to the super-market, or send the three-year-old to nursery school. The hospital ward may favor cross-infection. Meddlesome tonsillectomy is to be avoided even more strenuously than in the normal child. The recognized susceptibility of normal children to infections of the lower respiratory tract following tonsillectomy suggests that these glands play the protective role of "policemen of the pharynx."

Respiratory infections, once established in these children, may be difficult to eradicate. More frequently than not, the microorganism causing the infection is stubbornly resistant to any sort of antibiotic barrage. Oxygen may make the patient more comfortable. Special effort should be made to maintain adequate nutrition. Pulmonary infection may simulate heart failure and may indeed produce it, so digitalization is frequently desirable.

The treatment of heart failure amounts, in simplest terms, to the administration of digitalis. The dose for digitalization is at least 0.015 gram of digitalis or 0.015 milligram of a purified glycoside per pound of body weight. About one-tenth of this amount suffices for maintenance. The

response to digitalis is usually fairly satisfactory. The first and most striking sign of improvement is apt to be lessened irritability and fretfulness. The liver becomes smaller, and breathing may be less labored. It is not likely that tachycardia will be greatly affected, and the heart should not be expected to become smaller. It should be remembered that the effect of digitalis in patients with severe pulmonary hypertension may be deleterious.

Digitalis is easily administered to infants in liquid form, but the dose should never be stated in drops unless a calibrated dropper is used. Tincture of digitalis, dropped into an infant's mouth in accurately measured volume from a tuberculin syringe, is cheap and efficient.

The treatment of patients with right-to-left shunts is chiefly the management of syncopal and dyspneic attacks. Oxygen, which is otherwise without value in patients with cyanosis due to a right-to-left shunt, should be given in a concentration approaching 100 per cent—but only if its administration does not upset the patient. Even 100 per cent oxygen causes only about a 10 per cent rise in arterial oxygen saturation, but this may be the margin between life and death in an unconscious infant. By far the most effective measure in the treatment of severe dyspnea is the administration of morphine, which is given subcutaneously in a dose of approximately one milligram per 10 pounds of body weight; its beneficial action is apparent within five to 10 minutes. For some hours after morphine administration the skin may exhibit a gray pallor which is probably more disturbing to the physician than to the patient.

The hemoglobin should be estimated in every cardiac patient with syncope, particularly if there are repeated attacks. If low it should be raised to approximately 15 grams per 100 cc. by blood transfusion.

Epilogue

To the clear-cut urgent indications for seeking the aid of the pediatric cardiologist, may I in closing add another—also clear-cut, but of an urgency which is communal rather than individual, and consequently enduring rather than transcendental. I believe that all children with congenital heart disease, severe or mild, should at some time have the opportunity of a full dress evaluation. Maybe the fancy studies will help each individual child, though more probably they won't. They will, however, help other children, perhaps as yet unborn, by adding to the knowledge of those

persons who have particular interest in the disturbed hemodynamic mechanisms of congenital heart disease. With this knowledge we, as clinicians and physiologists, can achieve increasing sharpness of diagnostic acumen and clarity of judgment which, together with rapidly advancing surgical skills, will result in the selection of ever increasing numbers of handicapped children for a potentially more abundant life.

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Fetal Anomalies

Requiring Cesarean Section

THERE ARE A NUMBER of well known indications for cesarean section. In general they involve situations where the life of mother or baby would be endangered by vaginal delivery. In almost all cases the fetus is alive, and section usually gives it its best chance for survival. Ordinarily a fetus that is already dead, or has no chance of living, is delivered from below.

We wish to present two cases from the practice of the Toccoa Clinic. The first of these is a case of *teras katadidymus*, and the other is a case of *exencephalus* with cerebroplacental adhesions.

It might be argued that these cases could have been delivered vaginally by an experienced obstetrician, although mutilation of the abnormal fetus would have been required. In our small community hospital where an obstetrical specialist was not available, but an experienced surgeon was on hand, cesarean section was the method of choice. In each case the mother made a good recovery. The two case reports follow.

Case Report No. 1

Mrs. W. W. was a 24 year old white woman who called us to the hospital on December 20, 1948, because she thought she was in labor. She had been married about a year. An elderly physician in a small country town had been taking care of her, but he had died several weeks before. This was the first time we saw this patient.

Physical examination did not reveal anything unusual except pregnancy at term. Her pain turned out to be false labor, and after a few hours it subsided. While she was in the hospital pelvimetry was done, using Dr. Torpin's¹ method. The picture was too light, but there was enough detail to reveal an anthropoid pelvic inlet, the greatest transverse diameter was 12 cm., and AP 12 cm. The head was presenting. The patient was discharged from the hospital.

She came to our office on January 15. At that time she weighed 154 lbs. She stated that before pregnancy she had weighed 118 lbs. Her blood pressure was 120/80. There were no abnormalities in her urine.

We did not see her again until the night of February 3 when she came to the hospital about

WILLIAM H. GOOD, M.D., Toccoa, Ga.

10 o'clock in labor. Routine examination revealed an engaged head, high, and a normal fetal heart sound. Labor seemed to proceed slowly but normally. By the morning of the 4th the cervix was dilated about the size of a half dollar, and the patient seemed to have a posterior occiput presentation. Labor pains died then, and during most of the day the patient slept with very little discomfort. That night the pains became quite hard. By midnight she was almost fully dilated. Thus far her labor seemed like a slow normal labor, such as one might expect with posterior occiput. By the morning of the 5th, however, there had been no further progress.

She was given a sedative and I. V. glucose, and she slept four hours, after which pains returned, and she was put on the delivery table. She was fully dilated. The head was in mid-pelvis position with a right posterior occiput presentation. It was



Case 1



Case 1

decided to use forceps since she was making no progress.

Under ether anesthesia, forceps were applied, and after a number of short applications the head came down on the perineum and rotated to right occiput anterior. Midline episiotomy was made, and the head was delivered. As soon as the head was out there was complete arrest. The cord prolapsed, and we seemed to have a dead baby. After efforts to deliver the child failed, the hand was passed along the baby's back into the uterine cavity. It became evident that the baby had only one arm, the other shoulder being a nubbin. We also realized there was further abnormality. One could feel another head and shoulder, but not another body. It was obvious that normal delivery was impossible.

After a consultation between Drs. Good, Henry and Singer, it was decided to amputate the delivered head, and also an arm which had prolapsed during the maneuvers. The patient was transfused and taken to the operating room where, through a low transverse incision, an extra-peritoneal cesarean section was performed. The remainder of the fetus and the placenta were delivered. The wounds in the uterus and the abdominal wall were closed in the usual manner. The perineum was repaired, and the patient returned to the ward in fairly good condition. She made an uneventful recovery.

The patient went home and was seen in the office on February 26, at which time we noted that the abdominal wound was well healed without infection. She still has some leukorrhea, but it was not unusual. The perineum was healed. The vagina had healed with some scarring along the lateral wall from a tear which had been repaired at the time. There was a moderate amount

of anterior relaxation. She was followed for some time, and she continued to heal well.

About a year later the patient became anxious to have a baby, but as far as we know she has never become pregnant again.²

There are a number of indications for cesarean section which there is no need to discuss here; however, one seldom sees emphasis placed on the use of cesarean section in treatment of fetal anomaly. Indeed, it would seem that in the presence of a monstrosity one would prefer not to do cesarean section. However, this is one case where delivery from below would have been absolutely impossible, except by even more extensive mutilation of the fetus.³ We had a surgeon present but no obstetrical specialist. Therefore, we felt safer with the cesarean operation.

Looking back we feel we should have been more alert to the possibilities and should have made the diagnosis earlier. Our first x-ray made in December was not a good plate, or it might have tipped us off; however, it revealed the information we wanted at the time, and we did not take any other picture. This did not seem out of order.

On the other hand, when the patient became fully dilated and the head came down into mid-pelvis, and then, despite labor pains, did not progress over a number of hours, I believe we should have taken more pictures.^{4,5} If we had done so, we could have spared this patient the risk and ordeal of attempting forceps delivery with episiotomy and laceration of the vaginal wall before we realized the section was necessary, and she would have been taken to the operating room with much less risk. We feel fortunate that the end result was so good.

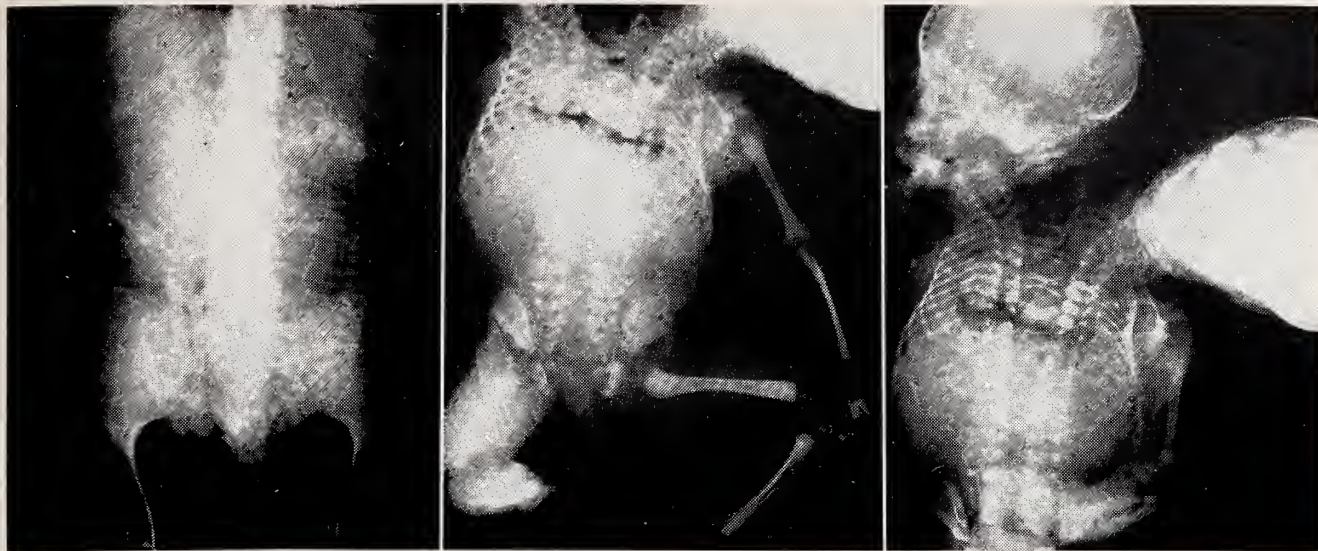
A discussion of this unusual fetal anomaly is in order. The autopsy report follows:

General Appearance: Two upper extremities
Two lower extremities
One main trunk
Two necks
Two heads

The heads and necks appeared normal. Extremities were normal except for a lump in the center of the upper back which represented the fused and incomplete right and left upper extremities of each twin respectively.

Trunk: There are two complete vertebral columns.

Viscera: Thorax: There are two sets of lungs and two hearts. The heart on the right is rudimentary. Hearts appear normal except for no



Case 1

evidence of a thoracic arch or an abdominal aorta. There is a single diaphragm.

G. I. System: There are two stomachs and two esophagi. Each stomach has a duodenum; these join to form a common ileum. There is a single large bowel. There is one liver, possibly fused from two, and two gallbladders.

G. U. System: There are two kidneys, that on the left being in the pelvis.

Genitalia: External genitalia are male. Internal on the right is a normal ovary and Fallopian tube.

DIAGNOSIS: *Texas Katadidymus:* double monster, originating from incomplete separation of identical twins.

Two headed children are certainly a rarity, despite the old story of the nitwit who used to tell people he had a brother with two heads at Harvard—in a bottle of alcohol, of course. But the important thing is not that we had a two headed baby, but the manner in which we handled it.

Case Report No. 2

Mrs. A. C. was a 19 year old, married, white woman. She came to the clinic in July 1950, six months after she had married. She had no previous pregnancies. It was obvious that she was pregnant. Her last menstrual period had been about May 2. There appeared to be nothing abnormal about her physical condition or her laboratory work. She was followed along with the usual prenatal routine.

On 13 January 1951 an x-ray was made as we routinely do with primiparae near term. The pelvic inlet was gynecoid. The greatest AP diameter was 10 cm. The greatest transverse diameter was 12 cm. Presentation was breech. A

flat plate of the abdomen revealed an abnormal skull which led us to believe the fetus was microcephalic.

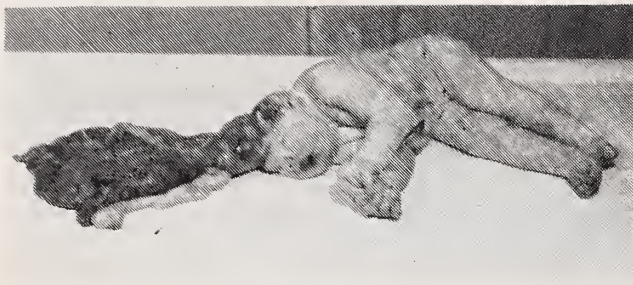
The patient went until March 31 without going into labor. The baby was alive and active. The patient felt well. She was obviously overdue; we sent her to the hospital and tried to induce labor by use of drugs. Another x-ray at this time confirmed the previous impression of an abnormality of the head. The cranial vault showed marked failure of development. Presentation was still breech. When labor did start, we elected cesarean section.

Under spinal anesthesia a low transverse incision was done. The baby and the placenta were delivered in one piece for reasons to be discussed. The uterus and abdominal wall were closed in the usual manner, and the patient made an uneventful recovery.

It was found that the monstrosity had an absence of some of the bones of the cranial vault, and the placenta and dura were firmly adherent at a place just adjacent to the insertion of the cord into the placenta. The baby lived for only a short time. After death the placenta and dura were pulled apart with great difficulty. The left parietal bone was absent and the right seemed intact. The baby had no eyes, and the left nostril was cleft. The family did not permit a post mortem examination.

DIAGNOSIS: *Exencephalus* with cerebro-placental adhesions.

Here again we have a fetal abnormality. This time we were more fortunate in recognizing the situation before any attempt was made at delivery. When the patient did not go into labor, we elected a cesarean section. It is quite possible that an



Case II

experienced obstetrician would not have done this. None of us at the clinic limits his practice to obstetrics, or has been especially trained in obstetrics. We feel that these questionable cases are safer in the hands of a trained surgeon doing cesarean surgery than they would be in that surgeon's hands doing a pelvic delivery by instrumentation or complicated manipulation from below. As it turned out, it was probably fortunate we did a cesarean on this woman, because, had we attempted delivery from below, we undoubtedly would have pulled the placenta off the uterine wall and would have encountered dangerous, possibly fatal, hemorrhage.

Here again is a case in which cesarean section seemed the method of choice, even though the fetus was a monster.

Summary

We have presented two cases from the obstetrical practice of the Toccoa Clinic in which monstrosity was encountered. Both cases were handled by cesarean section with excellent results for the mother. We feel that had any other method of delivery been attempted the results would have been less fortunate.

As a result of this experience we feel that fetal anomaly is sometimes a sound indication for cesarean section, especially in a small community hospital where a competent general surgeon may usually be found, but where there is seldom an experienced obstetrical specialist.

Toccoa Clinic and Hospital

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Nylon and Waterless Hand Cleaners

Contribute to Skin Disease

Nylon fabrics and waterless hand cleaners can cause or contribute to skin diseases of the hands and feet.

Reports on the two substances were made by Dr. George E. Morris, Boston, in the *Archives of Hygiene and Occupational Medicine* and by Dr. Robert G. Carney, Iowa City, in a recent *Archives of Dermatology and Syphilology*. Both are published by the American Medical Association.

Dr. Morris said many waterless hand cleaners, which are used widely in industrial plants, are based on cold cream, soap, or synthetic detergents. However, the only waterless cleaner of any value to the "really dirty worker" is one based on such solvents as kerosene or benzene.

These solvents are "especially hazardous" since they sensitize and irritate at the same time. He

said such cleaners are not only dangerous but are only "an expensive method of using kerosene as a skin cleaner."

Dr. Morris reported on nine cases of hand skin disease caused by using such hand cleaners.

Dr. Carney stated that nylon fabrics may be an important factor in producing and prolonging skin diseases, particularly in persons with foot diseases involving the circulation.

"This appears to be due to the lack of absorbency of nylon and suggests the possibility that nylon fabrics may promote or contribute to other disorders in which sweating and moisture are factors," he said.

He described cases in which such foot diseases were aggravated whenever the patients wore nylon hose and alleviated when they changed to silk or cotton.

Management of Hypertension in General Practice

MAURICE L. B. CLARKE, M.D., Atlanta, Ga.

IT HAS BEEN REPORTED that there are 15 to 18 million hypertensive patients in the United States.¹ In the vast majority of these patients hypertension is first diagnosed by the general practitioner, and many are seen by no other physician. It is therefore essential that the general practitioner be aware of the many recent advances in therapy for hypertension. Proper management of the hypertensive patient may allow him a fuller, happier life, less hampered by restrictions, and probably a greater life expectancy. These may now be achieved, in a gratifying percentage of patients, without the use of heavy sedation.

What are the proper steps to be taken in the management of the hypertensive patient by the general practitioner? It is a truism that each patient presents an individual problem, but the following general rules will apply in all cases:

1. The hypertension must first be classified etiologically. The type of hypertension must be determined; i.e., whether the patient has essential hypertension or hypertension due to known causes. About five per cent of the total number of hypertensives present evidence of pheochromocytoma, coarctation of the aorta, unilateral kidney disease, toxemia of pregnancy, Cushing's disease or acute glomerulonephritis. These patients, with the exception of those with toxemia of pregnancy, are not good candidates for hypotensive drug therapy; surgical intervention may be indicated in some. The hypertension associated with toxemia of pregnancy is one of the specific types of hypertension amenable to hypotensive drug therapy.

2. In essential hypertension, the degree and/or grade of hypertension must be determined, its rate of progression estimated, and a therapeutic regimen suitable to the particular situation planned. If advanced atherosclerosis is present the more potent hypotensive agents must be used with extreme caution, as a too rapid or too great reduction in blood pressure levels may be dangerous.

When medical therapy appears necessary (and

this group of patients includes most cases of essential hypertension), a therapeutic program is devised to suit the individual case. This program includes some or all of the following measures:

- a. Advice on physical and mental relaxation.
- b. Suitable psychotherapy when indicated.
- c. Weight reduction when obesity is present.
- d. Salt restriction, when practicable.
- e. Suitable drug therapy.

The purpose of this communication is to discuss drug therapy in view of the rapid advances in this field in recent years.

Contrary to the situation less than 10 years ago, there are available today a large number of potent and effective hypotensive agents. The chief problem is to select the agent or agents most suitable for the individual case. In general, the hypotensive agents may be put into five general groups:

- a. Sympathetic or adrenergic blocking agents. *Example: Dibenamine.*
- b. Ganglionic blocking agents. *Examples: Hexamethonium, pentapyrrolidinium, tetraethylammonium (TEAC).*
- c. Centrally acting agents. *Examples: Rauwolfia serpentina, Veratrum viride, l-hydrazinophthalazine, dihydrogenated ergot alkaloids.*
- d. Vasodilators. *Examples: Thiocyanates, nitroprusside, pyrogens.*

From these many agents, the practitioner must select the best agent for use. This cannot be done in the abstract, nor does any generally available scheme allow prediction of which agent will work best in a given situation. Several investigators²⁻⁵ have suggested a relatively simple therapeutic progression which assures that optimal treatment can be obtained for each hypertensive. In such a procedure, one starts with the milder agents and gradually progresses to more and more potent drugs until the desired response is obtained.

It has been established that *Rauwolfia serpentina** is the mildest and safest of the effective hypotensive agents.^{2-5, 4} Therapy for most patients

*Rauwiloid (R)

is begun with this drug, in addition to other indicated measures. In the majority of patients with mild and labile hypertension this agent alone will suffice. Ordinarily a subjective sense of well-being precedes the objective changes in blood pressure and pulse rate (a mild bradycardia is produced). This sense of well-being often so encourages the patient that he becomes more cooperative with regard to further treatment and supervision.

For patients with mild to moderate hypertension who fail to respond to Rauwolfia alone, a combination of Rauwolfia and Veratrum viride** may be prescribed. This usually will produce the desired blood pressure reduction. Such combination therapy preserves the subjective benefits characteristically produced by Rauwolfia, with the added effect of a potent, yet safe hypotensive agent—veratrum. The latter drug is often erroneously called "toxic." In clinical practice it is actually very safe, being free from organ toxicity. However, its usefulness has been limited by its tendency to produce nausea and vomiting. When used as Rauwiloid plus Veriloid, this unpleasant (but not dangerous) side action of veratrum is much less likely to occur.^{5 6}

In patients with moderate to severe hypertensive disease or with evidence of progression, calling for prompt lowering of blood pressure, it may be advisable to start with Rauwolfia and Veratrum combination therapy at the onset. This will relieve symptoms rapidly and produce more certain control than can ordinarily be obtained in such cases with Rauwolfia alone.

For patients presenting evidence of severe or rapidly progressing hypertension, prompt lowering of blood pressure is desirable. In such cases Rauwolfia may be combined with a potent ganglionic blocking agent such as hexamethonium. Though hexamethonium is a difficult drug to use from the standpoints of both physician and patient, its use is justified in severe cases. When it is used in conjunction with Rauwiloid, its effective dose is markedly reduced and its notorious side actions are minimized.^{4 7 8}

Hypertensive crises and encephalopathy call for immediate and vigorous therapy. In such cases parenteral veratrum therapy†† should be started at once and the pressure reduced to safer levels immediately. Subsequently appropriate oral therapy may be instituted.^{9 10}

**Rauwiloid plus Veriloid (R)

†Rauwiloid †Hexamethonium (R)

††Solution Intravenous and/or Intramuscular Veriloid (R)

Hypertension of pregnancy, pre-eclampsia and eclampsia may be handled as hypertensive crises, and therapy is started with parenteral veratrum, subsequently followed by oral therapy with Rauwolfia and veratrum.¹

The routine use of such a progressive, yet relatively simple, therapeutic screening process offers the best assurance that optimal treatment will be obtained for most hypertensive patients. It has the advantage that the more potent and inherently more dangerous hypotensive agents will not be used unless the patient's status warrants the additional risk.

The following case reports are illustrative:

CASE REPORT I

Mrs. H. C., age 26, married, para two, one living child and one spontaneous miscarriage. History of renal calculi and hematuria following the abortion. She was first seen during May 1953, at which time the blood pressure readings were: Right arm, 168/114, sitting; left arm, 168/118, sitting, and left popliteal fossa, 226/144. Urine concentration and dilution tests were negative and the Regitine test for pheochromocytoma was negative. She was given Rauwiloid, two tablets (2 mg. each) at bedtime, beginning November 29. On December 21 her blood pressure had fallen to 126/90, and she was asymptomatic. On January 4, 1954, the reading was 132/80, pulse 64. She was still asymptomatic and the Rauwiloid was reduced to one tablet three times per week. On January 26 the reading was 128/80, and on March 1, in the right arm the reading was 150/98; in the left, 152/108, although she had been taking one tablet once weekly. Rauwiloid was increased to one tablet daily at bedtime, and on March 11 her blood pressure readings were 130/88 (Right) and 138/80 (Left). Dosage was reduced to one tablet three times weekly, the blood pressure has since remained at about 120-130/80-85, and the patient is asymptomatic.

Comment: This case illustrates the efficacy of small doses of Rauwiloid and the principle of using the minimal effective dose.

CASE REPORT II

Mrs. L. S., age 36, married, para one. Past history includes a toxemia of pregnancy 13 years previously. At the time of her initial visit, the blood pressure was 180/100; pulse 64. She was nine pounds over her optimum weight and of pyknic habitus. Basal metabolic rate was minus 22 per cent corrected. Blood chemistry: BUN—18 mg. per cent, NPN—40.9 mg. per cent, Cholesterol—267 mg. per cent and glucose—85 mg. per cent.

In addition to other appropriate therapy she was given Veriloid which produced only modest falls in blood pressure. Subsequently, she was placed on a schedule of two tablets of Rauwiloid at bedtime, plus Veriloid two mg. three times a day. On this program her blood pressure ranged from 100-120/60-70, and her pulse rate was 50-60. Because of complaints of enervation and mild nasal congestion, all medication was temporarily discontinued. A week later her blood pressure had risen to 150/98, but her complaints had disappeared. Her pressure was not allowed to return to pre-treatment levels, but Rauwiloid was reinstated at this time, one tablet at bedtime. On this modest dosage her blood pressure fell to 118-68. Further gradual reduction in dosage of Rauwiloid demonstrated that in this patient it is possible to maintain the blood pressure in the range of 120-130 with a dose of Rauwiloid of one tablet three times weekly. Her emotional reactions were less labile, and her previously frequent headaches had disappeared. In December 1953, after approximately six months on this program, an intercurrent

episode of acute regional jejunitis necessitated hospitalization and laparotomy. At this time Rauwiloid was discontinued, but her blood pressure remained in the normal or near normal range.

In July 1954, she developed an episode of cystitis and some emotional problems, and her blood pressure rose to 210/104. She was started on Rauwiloid plus Veriloid with prompt fall of blood pressure to 154/90. Currently the dosages of these medications are being reduced, and it is probable that she will again be maintained on small doses of Rauwiloid alone.

Comment: This case again illustrates the principle of using minimum effective doses of hypotensive agents. It further confirms the frequently observed fact that when the blood pressure has been reduced and maintained at normal or near normal levels for a period of time, it may remain there with minimal therapy, or, occasionally, for long periods with no specific therapy.

CASE REPORT III

Mr. J. S., age 54. Patient was first seen on 4-23-54 for a routine examination for life insurance. He felt well and had no complaints referable to his cardiovascular system. Blood pressure was 200-230/120-140 in all extremities and in all positions. Physical examination showed moderate cardiac enlargement to the left but no evidence of congestive failure. Electrocardiogram showed left ventricular strain pattern, but other laboratory work was within normal limits.

During the next two months he was given a trial period of Rauwiloid alone, and then with first hydralazine, then Veriloid. Though he stated that he felt better than he had for some time previously, the blood pressure reduction was only moderate (175-190/100-110). Rauwiloid plus hexamethonium was then started, ½ tablet b.i.d., with graduated increments in dosage to one tablet q.i.d. On this medication alone pressure has fallen to near normotensive levels.

Comment: This case is illustrative of the few in which the use of hexamethonium is indicated. Hypertension of this severity, which fails to respond adequately to milder measures, deserves the use of the most potent agent available.

It is also noteworthy that this patient, like many others, felt much better subjectively while on Rauwiloid, despite the absence of specific complaints prior to therapy.

Discussion

There is still some divergence of opinion regarding the desirability of treating a patient with mild or asymptomatic hypertension. We feel that treatment of these patients is definitely indicated, in view of the current availability of safe and well tolerated drugs such as Rauwiloid. The advantages of such treatment are numerous. Frequently, patients will report striking subjective improvement, even if symptoms were not reported prior to therapy. Objective manifestations of hypertensive cardiovascular disease will often regress—congestive failure may improve, angina decrease and heart size diminish in response to hypotensive drugs alone. In addition, the decreased work load upon the heart and the probable slowing of the rate of development of atherosclerosis should lead

to greater life expectancy. Admittedly this last point requires statistically valid confirmation, and such confirmation should come from research centers, not from private practitioners. The duty of the physician in private practice is to offer to his patient the therapy which, in his opinion (based upon the best available information), offers the greatest hope for prolonging the happy, healthy and productive life. In our experience, a medical program similar to that outlined above seems to come closest to meeting these specifications.

Combination therapy appears to be not only rational, but virtually essential in the severe, rapidly progressing types of hypertension. Because the etiology of hypertension is so complex, it is unlikely that any one of the various hypotensive drugs is specific against all the causes. The experiences of numerous investigators in the field indicate that proper combinations of drugs are more effective than any one alone.^{4 5 6 7} For example, Rauwolfia not only appears to potentiate the hypotensive action of veratrum, making possible the use of smaller doses, but also directly reduces the incidence of nausea and vomiting. Thus combined therapy with Rauwolfia and veratrum* has distinct advantages over the use of either drug alone.

Though we seldom use hydralazine**, its unpleasant side effects also appear to be minimized by the simultaneous use of Rauwolfia. Whether this combination therapy will allow the use of doses of hydralazine which are small enough to avoid the chronic toxicity of the drug,^{12 13} remains to be demonstrated. For this reason we prefer the safer drugs, except in rare and special circumstances.

In the case of hexamethonium, clinical evidence^{3 4} indicates that the addition of Rauwolfia to hexamethonium results in two advantages. First the effectiveness of hexamethonium is so increased that smaller doses (50 per cent less in many cases) are effective. This, of course, correspondingly reduces the side effects of hexamethonium. Second, Rauwolfia—by virtue of its sedative action, its mild peristaltic stimulation and its bradycardic action—acts directly to prevent some of the more troublesome side effects of hexamethonium. Thus this combination*** is a rational one for the more severe cases of hypertension.

*Rauwiloid †Veriloid

**Apresoline

***Rauwiloid †Hexamethonium

Conclusions

1. Since most cases of hypertension are seen originally by the general practitioner, it is essential that he be well aware of the current advances in hypotensive drug therapy.

2. A complete physical survey of each hypertensive patient is essential before therapy is instituted.

3. Weight reduction, dietary control, salt restriction and suitable psychotherapy are used when and if indicated, and some of these measures may be necessary in every case.

4. Such general measures are to be supplemented with suitable drug therapy as indicated.

5. In the use of drug therapy, combinations of various hypotensive agents are required in many cases.

6. A progressive, yet relatively simple therapeutic screening program assures optimum treatment for each hypertensive patient.

7. In using combination therapy it is advisable to start with the milder agents, gradually adding the more potent agents as required.

8. In the order of their potency, therapy should be started with Rauwolfia extract, later adding veratrum extract, and finally, hexamethonium and/or hydralazine is added.

9. Oral drug therapy is practical in the great majority of cases. However, in very severe or malignant hypertension, or in hypertensive crises, therapy should be started with parenteral medication. Later, appropriate oral therapy may be instituted.

10. Hypertension of pregnancy, pre-eclampsia or eclampsia should be handled as severe hypertension or hypertensive crises, i.e., starting with parenteral therapy, later changing to oral therapy.

Candler Building

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Leukemia Studies Section Established

Establishment of a Leukemia Studies Section in the Laboratory of Biology at the Public Health Service's National Cancer Institute was by Dr. John R. Heller, Institute director.

The new Leukemia Studies Section will be headed by Dr. Lloyd W. Law, a Public Health Service officer who has been studying factors affecting the development of leukemia in laboratory animals since he joined the National Cancer Institute in 1947. Among his most important contributions to this field are (1) the demonstration that the thymus, a little understood organ in the

chest, plays a distinct and specific role in the induction in mice, of acute lymphocytic leukemia, the type most frequent in children; and (2) a description of the mechanism and control of drug-resistance of leukemic cells in the experimental animal.

The Leukemia Studies Section will be responsible for formulating and executing the program of the National Cancer Institute in experimental leukemia. This work will include investigations directed toward improving the treatment of clinical leukemia and elucidating the etiology and pathogenesis of leukemia in experimental animals.

Mesenteric Cyst:

A Report of Three Cases

JOHN E. SKANDALAKIS, M.D., Atlanta, Ga.

IN THE TEMPORARY Hospital of Athens (Greece), we had the opportunity to operate on a case of pseudocyst of the mesentery. We encountered two more cases in Saint Joseph's Infirmary, Atlanta. Mesenteric cysts are not common abdominal tumors and therefore we decided to publish these cases quoting briefly the accessible international literature.

FIRST CASE REPORT

A 15 year old female from Poros Island was admitted to the Temporary Hospital of Athens with severe pain in the left lower abdominal quarter which had begun two days previously and which continued until the day of admission. The patient stated that "something broke in my stomach, and I felt like I had a small lump in my stomach that got bigger." The pain was local, constant, without radiation, and it was accompanied by nausea, vomiting and high fever (102-103°F.). Her bowel movements were normal. Her menses were regular, and she denied any serious illness. The parents of the girl said that she had always enjoyed good health.

Examination of the head, neck, heart, lungs and extremities was negative. The liver, kidneys and spleen were not palpable. The right abdomen was normal. In the left lower abdominal quarter a spherical mass about the size of a very large orange was palpable. There was moderate tenderness in this area, and the patient tolerated our palpation with great difficulty. During and after the examination the pain was worse. Rectal examination revealed a normal uterus and space of Douglas.

Laboratory reports of the blood were normal except the white blood cells were elevated to 18,400. The urine was normal. Casoni reaction negative. Barium enema was negative. A flat plate of the abdomen and spine films were negative. Intravenous and retrograde pyelography were negative. We gave her penicillin, streptomycin and ordered nothing by mouth. The fever and a down-hill course continued. Clinically the mass gave the impression that it was enlarging. No diagnosis could be made and we decided on exploration because the over-all clinical picture indicated "a local encysted peritonitis of unknown etiology."

Pre-operatively our diagnoses were as follows:

- (1) Abscess of unknown etiology
- (2) Pus filled echinococcus cyst of the omentum
- (3) Floating kidney
- (4) Twisted ovarian cyst
- (5) Retroperitoneal tumor

From the date of admission the patient continued a high septic fever. Generally the onset was that of a septic process.

The fifth day after admission a surgical exploration was performed under general anesthesia with ether and pentothal. Through a vertical left rectus incision the peritoneum was opened, and a small amount of dark yellow fluid escaped. A large cyst with a red glistening wall was evident. Many loops of the small intestine were adhered to its wall, and generally there was a local infection. (Pseudomembranes). With a trochar we drained its fluid and delivered it from the abdomen. The fluid was brownish red in color and semi-

thick. We tried with difficulty to separate the loops of the small intestine from the wall of the cyst. Small serosal bleeding points of the bowel were controlled with clamps and ligated with 000 plain catgut. The cyst arose from the mesentery of a loop of the ileum. The effort to separate the cyst from the leaves of the mesentery was not successful because we were afraid that we would destroy the blood supply of the intestine. The general condition of the patient was very poor, and we decided on marsupialization rather than resection of the intestine. Large segments of the cyst were removed following this procedure.

The pathology report was as follows: (Professor Eleftheriou) "The specimen submitted is that of the wall of a mesenteric cyst which measures 0.2-0.4 cm. in thickness. Attached to the external surface there is fatty hemorrhagic connective tissue as well as fibrous tissue adhesions. The internal surface is relatively smooth, and in many places there seems to be a pseudomembranous lining, while in other areas one sees hemorrhagic infiltrations.

"Histologically the wall of the cyst is composed of dense fibrous connective tissue containing a great number of blood capillaries. A greater number of cells, nuclei and vessels are seen to exist in the connective tissue toward the medial surface of the wall. There is a dense inflammatory cell reaction consisting of polymorphonuclear leukocytes, lymphocytes and plasma cells as well as areas of hemorrhagic infiltration. There is no apparent epithelial cell layer on the external surface of the cyst. The above mentioned covering seems in many areas to be a pseudomembranous fibrous network within which are seen a great number of leukocytes. The remainder of the wall of this section of the cyst is seen to contain less dense leukocytic inflammatory cell reactions.

"The contents of the cyst has the consistency of a semi-fluid and is of a dirty reddish-brown color. Microscopically one sees the remnants of destroyed red blood cells with a good bit of hemosiderin deposits within phagocytes, as well as the remnants of pus cells and a few as yet undestroyed white blood cells.

"CONCLUSION. The section of the 'pseudocystic' wall is formed from the development of a reactive inflammatory exudate of connective tissue enclosing old hemorrhages or a collection of hemorrhagic inflammatory exudate.

"No special type of inflammatory or malignant neoplasm was found in the submitted specimen of the wall of the cyst."

The post-operative course was uneventful. After the third post-operative day the dressing was quite dry. We removed the stitches on the eighth post-operative day, and the patient left the hospital in good health with the advice to have a check-up three times every year. (We were cognizant of the sixth case of Beahrs et al⁴ which recurred after one year and in which developed grade two leiomyosarcoma after two years.)

SECOND CASE REPORT

This 72 year old white female presented with a mass in her left lower quadrant, being painless and asymptomatic. She noted this mass moved freely and attributed her chronic constipation to it. Physical examination revealed a non-tender freely movable mass about the size of a baseball in the left lower quadrant. The remainder of the examination was normal. CBC and urinalysis were normal.

With the diagnosis of intra-abdominal tumor, the patient was operated on 8-31-53, and a tumor lying in the splenic flexure of the colon was identified. The tumor was densely adherent to the lower pole of the left kidney. The cyst arose from the mesentery of the colon, and it was found to occupy the area of the blood supply to the splenic flexure

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of the colon. Accordingly, resection of the splenic flexure of the colon became mandatory. A segment of the colon was resected with the mesentery including the cyst. The bowel continuity was restored by end to end anastomosis. The pathology report was as follows. (14932 8-31-53)

"The specimen consists of a strip of large intestine 15 cm. long attached near one end of which along the mesentery border is a cyst six cm. in diameter. The surface of the cyst is reddish brown. Upon opening the cyst, its contents are composed of brownish fluid with a considerable amount of brown sediment. The internal surface of the cyst is greyish white, smooth and shining. On gross examination the cyst does not appear to invade the wall of the intestine. The intestine is open throughout its length. The mucosa is completely normal on gross examination, and it is intact.

"The sections made of the cyst wall show it to contain bits of dense fibrous tissue, with a heavy collagen content. In the wall there are lymphocytes and other round inflammatory cells in moderate numbers. The lining of this cyst is of fibrous tissue or granulation tissue, in which there are many macrophages filled with lipoid or blood pigment. No epithelium is present, and there is no suggestion as to the original cause of the cyst. There is no indication of malignancy. Sections of the intestine reveal no remarkable features. The mucosa is intact. The wall is a fairly heavy and muscular one. Such cysts as this one are hard to explain as they are not adequately described in the literature. They are not malignant and do not recur. This is very probably some type of unusual congenital cyst whose epithelial lining has disappeared."

The post-operative course was uneventful.

THIRD CASE REPORT

This 68 year old white female was told by her doctor two to three years prior to admission that she had a mass in the abdomen. Examination on admission revealed a firm, non-tender, movable, hard and regular mass the size of an orange in the epigastrium and upper umbilical area. Past medical history was irrelevant except chronic constipation and hypertension during the last five years. Patient stated that "this tumor never bothered me." With the diagnosis of an "intra-abdominal mass, possible omental cyst," the patient was operated on 12-10-54. An omental cyst 3.5 cm. in diameter was identified on the inferior portion of the omentum and another one (8 cm x 5 cm), located in the mesentery of the proximal ileum. The cyst rested directly on the superior mesenteric artery. It was enucleated completely after careful sharp dissection. The cyst contained a white, pasty-looking material. The omental cyst was excised with a small portion of the omentum. The pathology report was as follows:

"The specimen consists of two dissimilar large cysts. The

largest cyst measures eight cm. in the long diameter by approximately five cm. across. This cyst is reported to have been removed from the mesentery. It is soft and mushy in consistency. When cut it is shown to contain a greyish white caseous exudate. This caseous material is encapsulated by a thin membranous material. The internal surface is smooth.

The other cyst is reported to have been removed from the omentum and consists of a rather spherical shaped mass, measuring approximately 3.5 cm. in diameter. It is attached along several cm. of one surface to a large tag of fat. The fat measures approximately five cm. in one length, approximately 2.5 cm. across and approximately one cm. thick. The surface of this cyst is mottled to a brownish to brownish-red color. Cut section shows this cyst to contain a large mass of brown caseous material enclosed in a thin membranous capsule.

"The sections show a nodular or cystic structure whose wall is made of fibrous tissue and whose lining contains cholesterol crystals. There is a great deal of scar tissue in the wall of this cystic structure. In the wall there are scattered lymphocytes. No epithelium is present in the specimen. There is nothing to indicate malignancy."

The post-operative course was uneventful.

History

The first description of a mesenteric cyst was by the great Florentine physician Antonio Beniveni⁷ (1440-1502), the so called "father of pathologic anatomy," in 1507 at the autopsy of an eight year old boy. In 1842, Rokitsky⁴⁹ noted at autopsy a chylous cyst. Tillaux,⁵⁴ in 1880, seems to be the first surgeon who operated upon one of these tumors. Three years later (1883) Pean⁴⁵ using marsupialization treated with success a mesenteric cyst. In 1890, Carson¹³ reported the first case in the U.S.A. In 1900, Dowd¹⁵ presented another classification, and from this period to the present time many classifications have been advocated: Nye-Wilkins⁴² (1911), Carter¹⁴ (1921), Hueper³² (1926), Lahey-Eckerson³⁵ (1934), Roller⁵⁰ (1935), Peterson⁴⁶ (1940), Beahrs et Al.⁴ (1950).

TABLE I

Name	Theory
Rokitsky ⁴⁹	Degeneration of lymph nodes
Carson ¹³	Degeneration of lymph nodes
Hill ²⁹	Congenital malformation of the lymphatic vessels
Godel ²¹	Neoplasia in the presence of lymph vessel hyperplasia
Handfield-Jones ²⁷	Developmental anomalies
Arzella ¹	Developmental anomalies
Lee ³⁶	Traumatic origin
Ewing ¹⁶	Traumatic origin
Guthrie-Wakefield ²⁴	Embryological origin from true diverticula of the small intestine which grew into the mesentery and became pinched off.
Gross-Ladd ²³	"Misplaced bits of lymphatic tissue which proliferate and they accumulate fluid because they do not possess communications which allow them to drain properly into the remainder of the lymphatic system."
Beahrs et Al. ⁴	"It is felt that chylous cysts do not have a common mode of origin but may come from several sources."

TABLE II

<i>Names</i>	<i>Year</i>	<i>Classification</i>
Moynihan ⁴⁰	1897	(1) Serous cysts (unilocular or multilocular) (2) Chylous cysts (unilocular or multilocular) (3) Hydatid cysts (4) Blood cysts (5) Dermoid cysts (6) Cystic malignant disease.
Dowd ¹⁵	1900	(1) Embryonic (2) Hydatid and (3) Cystic malignant disease.
Nye-Wilkinson ⁴²	1900	(1) Blood cysts (2) Dermoid cyst (3) Chyle cysts (4) Hydatid cysts (5) Cystic malignant diseases (6) Serous cysts.
Niosi ⁴¹	1907	(1) Cysts of intestinal origin (a) By sequestration from the bowel during development (b) From Meckel's diverticulum (2) Dermoids (3) Cysts arising from retroperitoneal organs (germinal epithelium, ovary, wolfian body, muellerian duct).
Carter ¹⁴	1921	(1) True Mesenteric cysts: (a) Embryocystomata (b) Enterocystomata (c) Obstructive, possible (2) Dermoids (3) Cystic malignant disease (3) Parasitic.
Hueper ³²	1926	(1) Cystic lymphangiomas (Serous + Chylous) (2) Enterocystomas (3) Cysts being derived from the wolfian duct (4) Dermoid cysts (5) Teratomas (6) Fetal inclusions (7) Teratoid mixed tumors.
Lahey-Ekerson ³⁵	1934	(1) Wolfian (2) Lymphatic or chylous (3) Dermoid (4) Mesocolic (5) Parasitic and inflammatory (6) Traumatic hemorrhagic cysts.
Roller ⁵⁰	1935	
Peterson ⁴⁶	1940	(A) Embryonic (1) Arising from embryonic remnants and sequestered tissue (Serous + chylous + sanguineous + dermoid) (2) Intestinal origin (sequestration of the bowel and diverticula) (3) Arising from urogenital organs (Germinal epithelium + ovary + wolfian body + Mullerian duct) (B) Pseudocysts (1) Infective origin (hydatid + degenerated tuberculus nodes) (2) Cystic Malignant diseases.
Ewing ¹⁶	1940	True chylangiomas due to congenital or acquired obstruction of lacteals.
Beahrs et Al. ⁴	1950	(1) Embryonic and developmental, (2) Traumatic or acquired cysts, (3) Neoplastic cysts, (4) Infective and degenerative cysts.
Gross-Ladd ²³	1953	(1) True mesenteric (lymphatic) cysts (2) Enteric cysts (Duplications).
Frazier ¹⁸ (modification of one used by Moynihan)		(1) Serous (lymphatic dilatation or hemorrhages between the layers of mesentery) (2) Chylous (dilation of some of the lacteals or chyloferous vessels or possibly to an effusion of chyle into preexisting cyst) (3) Hydatid (4) Dermoid (5) Sanguinous.

Terminology

In the literature there are the following terms: "Hematoma of the Mesentery," "Lymphangioma," "Hemorrhagic Cyst of the Mesentery," etc.

Lately many of the authors have used the term "Mesenteric Cyst."

Frequency

Mesenteric cyst is one of the rarest of mesenteric tumors. According to Martin et Al.³⁸ (1954) there have been recorded only 600 cases. From 1900 to 1926 at the Massachusetts General Hospital only six were recorded. (Slocum,⁵¹ 1938). The statistics of the same author report one case in over 93,000 admissions at the University of California Hospital, and one case in over 188,000 admissions at the Los Angeles General Hospital. Beahrs⁵ and Judd (1947) wrote that there have been only seven cases at the Mayo Clinic in more than one million patients. Block⁹ (1948) reported the first case in the Jewish Hospital (Philadelphia, Pa.) in over 160,000 admissions. Gross²³ and Ladd (1953) have only 12 patients with isolated mesenteric cysts. At Saint Joseph's Infirmary, Atlanta, we have found only two cases of mesenteric cyst in 67,000 admissions since 1922.

Etiology

"Their origin is somewhat of a mystery" (Homans)

Hadly,²⁶ according to Beahrs et al.,⁴ believes that the only way to determine the nature of a cystic tumor is by a study of its life history, its location, the structure of its wall and the character of its content.

But who can explain the case of Genkin,²⁰ who mentions "a chylous cyst of the mesentery which had formed around a piece of gauze left at operation?" (Thorek)⁵³

Classification

Many authors in this century tried to classify the tumors of the mesentery. Their opinions are stated here in the form of a table.

Clinical Findings—Diagnosis—Differential

Diagnosis

"An accurate diagnosis is seldom made before operation" (Block⁹)

There are no pathognomonic signs, symptoms or diagnostic criteria of mesenteric cysts. So the preoperative diagnosis of a mesenteric cyst is perhaps impossible. A preoperative diagnosis of abdominal cyst is feasible, but one can only postulate its mesenteric origin.

"The symptoms may be of three sorts" (Gross-Ladd²³ (1) enlarging abdomen (painless), (2) abdominal pain and (3) intestinal obstruction. Cases with intestinal obstruction were noted by the following authors: Pray,⁴⁸ Brown,¹² Gross-Ladd²³ and others. Such a condition presents the following complications: secondary peritonitis, rupture or hemorrhage into the cyst. This trilogy of course, although it is the basic support of the diagnosis, is not characteristic and depends upon the size, location and onset.

In our first case we had a painful, rapidly enlarging abdomen, with high fever (102-103°F.), nausea and vomiting. According to Handelsman²⁵ and Ravitch, "In Burnett,¹¹ Rosemond and Bucher's collective review of the history in 71 cases, pain was the presenting symptom 82 per cent of the time." The second and third cases were asymptomatic.

According to Moynihan⁴⁹ the clinical signs of mesenteric cysts are: (1) the presence of a fluctuant tumor, (2) the great motility of the tumor especially transversely and (3) a zone of resonance around and a belt of resonance across the tumor.

Palpation gives "an elastic non-tender, forward-lying mass" (Gross-Ladd).²³ Sometimes if the cyst is large, it gives a fluid wave. Mesenteric cysts do not move with respiration. Sometimes these tumors are quite silent.

According to Keesey,³³ the differential diagnosis must include floating kidney, floating spleen, renal tumor, hydronephrosis, encysted tuberculous peritonitis, hydrops of the gallbladder, ovarian cyst, pyosalpinx, extra-uterine pregnancy, pedunculated uterine neoplasms, retroperitoneal tumor, pancreatic cyst, intestinal neoplasms, appendicitis, cholecystitis, intussusception and perforated peptic ulcer. X-ray examination has been given relatively little credit in the diagnosis. It is useful in excluding other lesions. Barium swallow or enema with fluoroscopic palpation will give information as to the position of the mass in relation to neighboring organs. Generally the X-rays show a gasless shadow, displaced or dilated intestine, and at times communication with the intestine. Hinkel³⁰ (1942) localized the mass in three patients using this examination.

Pathology

Having in mind a great part of the mesenteric

TABLE III

<i>Mesenteric</i>		<i>Enteric</i>	<i>Observations on our first case</i>	<i>Observation in our second case</i>	<i>Observation in our third case</i>
Wall of the cyst	Thin. "Rarely more than 1-2 mm. It consists of connective tissue."		0.2-0.4 cm. The wall was infected and edematous. It consists of connective tissue	It contains bits of dense fibrous tissue	Fibrous tissue. 0.5 mm.
Serous Coat		Yes	No	No	No
Muscle Coat	No	Yes. 2 layers of smooth muscle	No	No	No
Mucous Membrane	No. Smooth inner surface	Yes	No. The inner surface was relatively smooth	Internal surface of the cyst greyish white and smooth and shining	Smooth
Blood Supply	Between cyst and intestine "there is line of cleavage."	The same of the adjacent gut		The cyst does not appear to invade the wall of the intestine	
Fluid	Serous or Chylous	Clear or hemorrhagic or murky and sometimes succus entericus or fecal material	The fluid was, thick red-dish-brown and measured about 800 grams	Brownish fluid with a considerable amount of brown sediment	Greyish white caseous exudate weighing 120 grams
Size and Shape	Orange or Grapefruit	Vary tremendously in shape and vary greatly in size	It resembled a large orange	Like a baseball	Like an orange
Operation	(1) Resection and primary Anastomosis (2) Marsupialization (3) Dissection	Resection and direct anastomosis or Mikulitz procedure	in our case we marsupialized the cyst because of the tremendous local infection	Colon resection including the mesentery and the cyst. End to end anastomosis	Complete Enucleation
Symptoms	Enlarging abdomen. Abdominal pains. Intestinal obstruction	Obstruction. Pain. Necrosis, sloughing, bleeding, Hemorrhage	Painful rapidly enlarging abdomen with high fever, nausea and vomiting	No symptoms	No symptoms

cyst's literature, we think that the best classification is that of Gross-Ladd.²³ In this simple classification (lymphatenteric) the authors emphasize this: "It is desirable to distinguish between them because they are pathologically different and because they require quite different forms of therapy."

The true mesenteric cyst is thin walled (one to two mm., rarely more) and has no muscle coat or mucous membrane. There is a cleavage plane between the cyst and the intestine. It has a smooth surface and its wall is found "to consist of connective tissue." (Gross-Ladd)²³

Fluid within the cysts is chylous or serous. In 12 examples of Gross-Ladd,²³ seven had a serous and five a chylous fluid.

"Cysts may arise in any portion of the mesentery or the mesocolon." (Gross-Ladd)²³ From the 13 cases of Gross and Ladd,²³ six arose from the jejunum, five from the ileum, one in the transverse colon and one in the sigmoid. As far as we know, the most common origin of the mesenteric cysts is the small intestine (Cases of Block,⁹ Martin et Al.,³⁸ Oberhelman and Condon,⁴³ Brown¹² and Shaul, two of our cases and many others.) Keesey,³³ in a review of the literature, found mesenteric cysts to be "more common near the ileocecal valve and rare in the mesentery of the jejunum." (Bancroft-Wade)³ They lie between the leaves of the mesentery.

Mesenteric cysts vary in size. In the cases of Beahrs et Al.⁴ the size varied between eight cm. and 17 cm. According to Gross and Ladd²³ the cysts are "as large as an orange or a grapefruit." As for the number, they may be single (isolated) or multilocular (multiple cystic disease of the mesentery). (Gross-Ladd)²³

Table three shows the differences between mesenteric and enteric cysts, and observations pertaining to our cases.

Sex - Age

"Five of the nine patients with chylous cysts were women." (Beahrs et Al.)⁴ Eight patients of Gross and Ladd²³ were males, and five, females. Warfield⁵⁵ (1932) supported that the frequency is twice as much in women than men.

There is a case in the literature three days of age (Gross-Ladd)²³ and another which quotes over 60 years of age (Warfield⁵⁵ (1932)). Brown and Shaul¹² supported that "incidence is highest in the fourth decade and lowest in the first and sixth." The age in our cases was 15 to 72. They were all females.

Treatment

According to Gross-Ladd²³ the treatment is surgical, and it can be effected in one of three ways: (1) resection and primary anastomosis, if the cyst is unduly adherent to the intestine, (2) dissection and (3) marsupialization. The treatment of choice is dissection, and if this is impossible resection with anastomosis of the remaining ends may be done. We think that marsupialization is "the way of necessity."

The first step is to study the cyst through the open abdomen and to make the differential diagnosis between a real mesenteric or enteric cyst. Then one must try to displace all the important vessels of the mesentery. Then the dissection is easy. If this is impossible we must think of resection. We can't agree with Parsons⁴⁴ that marsupialization is an obsolete way. Perhaps "it is a necessary evil," but it is important when indicated. With marsupialization we had an excellent result.

Summarizing the operative aspects one should emphasize the following:

1. Always have in mind the blood supply of the intestine.
2. Carefully close the opened mesentery.
3. Avoid rough or ragged areas on bowel or mesentery.

Summary

1. Mesenteric cyst is an unusual abdominal tumor.
2. A brief review of the literature is presented.
3. It is evident from all sources that the signs, symptoms, and physical findings of this condition are varied and sometimes misleading.
4. The diagnosis is usually made at the time of operation.
5. A case report is included which the author operated successfully by marsupialization, and two other cases operated successfully by resection and dissection.

St. Joseph's Infirmary

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Safety of Fluoridation Supported

New evidence supporting the safety of adding fluoride to public water supplies as a means of preventing tooth decay among children has been received by the Georgia Department of Public Health.

Dr. John E. Chrietberg, director of the Department's Dental Health Services, says that he has just received the results of a U. S. Public Health Service survey which found that there were just as many deaths from all causes in non-fluoridated areas as there were in fluoridated areas.

Including 2,190,125 persons living in 64 cities in 16 different states, the survey found that in fluoridated areas the annual death rate was 1,010 per hundred thousand, and in non-fluoridated areas the death rate was 1,005 per hundred thousand, an insignificant difference. Actually, heart

disease, cancer and nephritis deaths were slightly less in fluoridated areas than in the non-fluoridated ones.

Although the statistical study was made in cities where fluoride occurs naturally in the water, Dr. Chrietberg pointed out that there is no difference in fluoridated water regardless of whether fluoride is added to it or whether fluoride occurs naturally.

"Twenty-four Georgia communities with a population of 255,532 are now receiving the benefits of fluoridation—a process that has been proved to prevent tooth decay by as much as 71 per cent," Dr. Chrietberg said. "Best results are derived from fluoridated water if it is consumed by children from birth to eight years of age; the benefits are retained throughout life," he added.

Dermatologic Application of a New Combined Calcium-Antihistamine Preparation

THE PURPOSE OF this paper is to briefly present results obtained with a new agent, l-methyl-4 amino-H-phenyl-N' (2' thenyl)-piperidine-tartrate (Sandostene®) for the treatment of various dermatoses. It was employed alone in tablet form and administered intravenously in combination with calcium gluconolactobionate (Neo-Calglucon®). Pharmacologic studies indicate that Sandostene possesses antihistaminic, local anesthetic, anticholinergic and powerful anti-permeability action.³

Prior to antihistaminics, intravenous administration of calcium was widely used in the therapy of various inflammatory, pruritic and exudative dermatoses.¹ Although many newer treatments for symptomatic relief of these dermatoses have been advocated, antihistaminics are still among the most frequently employed medications. The antihistaminics do not replace all the classic effects of calcium, just as calcium does not affect all the indications which are successfully controlled by antihistaminics. The need for study of a combination of these two well-known classes of therapeutic agents, therefore, was quickly appreciated.²

Materials and Method

A group of 70 private patients with a variety of dermatoses was treated with a preparation containing a mixture of an antihistaminic* and calcium. In addition, non-specific therapeutic measures (boric acid wet dressings, calamine emulsions, etc.) were applied to the affected areas. This study was aimed at evaluating symptomatic relief and the rapidity of action obtainable through the new agent. Therefore, no attempt was made to determine the etiology of the dermatoses.

Results were judged by improvement in subjective symptoms, reported by patients, and observations by the physician as to changes in outward appearance of skin lesions, especially in regard to exudation, if present.

WILLIAM L. DOBES, M.D., Atlanta, Ga.

Both parenteral and oral forms* were used. The ampule form contained 50 mg. of the antihistaminic--l-methyl-4 amino-H-phenyl-N' (2' thenyl)-piperidine-tartrate (Sandostene®) and 10 cc. of a 10 per cent solution of calcium gluconolactobionate (Neo-Calglucon®).

The tablets were employed in maintenance therapy and were of two sizes: the earlier ones contained 25 mg. of the antihistaminic, while the more recent research material contained 50 mg.; this form contains no calcium.

The dosage employed was as follows:

At start10 cc. (one ampule) daily i. v.
After sufficient relief.....10 cc. every two or
three days

In urticarial patients maintenance therapy consisted of four tablets (100 mg.) daily.

The usual procedure for the intravenous injection of calcium was to inject the material slowly over a period of two-three minutes. In most cases of this series, no attempt was made to control the rate of injection. The 10 cc. ampule was usually administered within 30 seconds. It was found that the rate of injection had no effect on the therapeutic results; also the heat sensation is not as pronounced as that produced by calcium alone. Slowing the rate of injection, however, apparently controlled the symptoms of those patients who complained of temporary nausea and drowsiness. The period of heat sensation was usually followed by partial or complete relief of itching.

Results

The indications were divided into large groups as a means of classifying the type of dermatoses

*Sandostene (Sandoz)—The preparation employed is still being evaluated clinically and should be released commercially March 1, 1955.

which respond best to this medication. Table I reports the results obtained in regard to relief of itching and exudation.

TABLE I TYPES OF DERMATOSES AND RESULTS OF SANDOSTENE PLUS CALCIUM THERAPY	
Types	No. of Cases
Urticaria	14
50-75 per cent relief	1
75-100 per cent relief	13
Average number of injections (10 cc. ea.):	
Acute Urticaria	4
Chronic Urticaria	19
Dermatitis	32
(contact, eczematoid, neuro-)	
No relief	3
Less than 50 per cent	1
50-75 per cent relief	18
75-100 per cent relief	10
Average number of injections	7
Atopic Eczema	11
Less than 50 per cent relief	3
50-75 per cent relief	6
75-100 per cent relief	2
Average number of injections	8
Pruritus Ani et Vulvi	5
50-75 per cent relief	3
75-100 per cent relief	2
Average number of injections	12
Senile Pruritus	2
50-75 per cent relief	2
Average number of injections	7
Lichen Planus	2
75-100 per cent relief of pruritus	2
Average number of injections	6
Pityriasis Rosea with Pruritus	1
75-100 per cent relief of itching	1
Average number of injections	4
Erythema Multiforme (eruption only)	3
Improvement with 6 injections	2
Cleared with 7 injections	1

Except for the treatment of urticaria, supportive therapy with oral tablets was not necessary. In this group of patients it was found that four tablets daily (100 mg.) was sufficient. The preparation was most effective in the control of urticarias and least effective in Nummular Eczema and in hand eczemas classified as eczematoid dermatitis in Table I. Treatment was discontinued if four injections failed to produce any signs of improvement. In order for this agent to be of any benefit, it had to be administered during the early stages of the condition.

Skin conditions will improve if exudation, eruption and itching are controlled. For this reason particular attention was paid to improvement of these symptoms. *Itching* was present in 66 of the 70 cases and was helped or controlled adequately in all but three cases. I believe this small series is sufficient to show the efficiency of this preparation in controlling this unpleasant accompanying manifestation of dermatologic conditions, even

though the effect may be only temporary. I am convinced that the percentage of good results would be only slightly changed in a larger series. The relief of itching was most remarkable in two cases of lichen planus. In spite of previous X-ray therapy and injections of bismuth subsalicylate, the itching was severe. Antipruritics did not give much relief. After six days of Sandostene injections, the pruritus stopped and did not recur. The eruption cleared after six additional weeks of bismuth therapy.

Exudation was present in 15 cases and failed to improve or be controlled in only three cases. It usually took two-three injections for the weeping to show improvement or subside. *Eruption* was present in all but two cases of pruritus ani et vulvi. The urticarial wheals would disappear with the symptomatic relief of itching. Where exudation was present and relieved, clinical improvement would follow as expected; otherwise the appearance of skin lesions was not considerably altered with Sandostene. In addition, after two or three injections, most patients welcomed relief from their nervous tension and the newly acquired ability to sleep restfully again at night. These changes contribute greatly to the emotional improvement, so integral a part of dermatologic therapy.

One of the features of the results of treatment was the almost complete absence of side-effects. Slight nausea lasting one hour at most, was reported in three or four instances. This was probably caused by a too rapid rate of injection. Two other patients complained of drowsiness following a rapid i. v. injection. These patients were obliged to lie down and sleep when they got home. This was not a particularly harmful effect, since in many instances this period of relaxation was of benefit to the patient.

Discussion

The value of this antihistaminic-calcium preparation seems to lie in its ability to control itching and exudation, associated with various dermatologic conditions. This may result from two of its properties:

a) *Low Toxicity*—The antihistaminic, itself 1-methyl-4 amino-H-phenyl-N' (2' thenyl)-piperidine-tartrate, has a low toxicity. Calcium is well-known as a detoxifying agent. The combination would be expected to have an extremely low toxicity, which animal studies show to be true.³ It has previously been reported⁴ that daily doses of 75 mg. to 225 mgm. (three to nine tablets) of

Sandostene alone do not produce side-effects. Another of the early reports⁵ on the use of this antihistaminic and calcium combination states that side-effects were mild and of short duration. They were primarily nausea, vertigo, fatigue and drowsiness. Apparently the addition of calcium to an antihistaminic helps reduce the number and severity of side reactions.

b) *Antipermeability Factor*—One of the marked effects we observed is the antiexudative action of this preparation. It has previously been reported⁶ that the Sandosten-Neo-Calglucon combination is more effective than the topical application of cortisone in reducing cell permeability.

The optimum effect on permeability is reached 40-80 minutes after intravenous injection of the combination, and the effect lasts for 10-15 hours. The combination was able to normalize cell permeability and normal permeability was further decreased, in contrast to the inability of antihistaminics alone to decrease normal permeability. In this series, one case of severe atopic dermatitis had been treated previously with cortisone without effect. A series of intravenous injections of Sandostene and Neo-Calglucon combination (two daily for one week) produced a marked reduction in the exudate, and dramatically aborted the severe itching. After one week, dosage was reduced to one injection daily, and after 10 days the patient was given 100 mg. of Sandostene daily by mouth. It is my opinion that the antipermeability effect of the drug was mainly responsible for the therapeutic success of this case.

The experimental results obtained with calcium and Sandostene justify the hope that these products will prove valuable additions to therapy. The cases treated in this series were mostly those who ordinarily are unstable and fail to remain in a doctor's care long enough to enable him to arrive at a specific form of therapy based on etiologic factors. Unless sufficiently prompt relief from

itching and exudation can be obtained, the patient seeks help elsewhere. In many of my cases satisfactory relief of symptoms was obtained after four days treatment, and further studies were unnecessary.

It could be said that almost any type of treatment will give some clearing of symptoms. Even the psychological effect of going to a doctor's office or the injection itself is likely to give the patient some reassurance and feeling of relief. In this series Sandostene was not used as a specific remedy for curing a disease, but for temporary relief of itching and exudation. When used for this purpose, results obtained with Sandostene were too striking and regular to be explained on a psychosomatic basis alone.

Summary and Conclusion

A new antihistaminic was employed in the treatment of various dermatoses. The effect of intravenous administration of this agent in combination with calcium was observed. It produced prompt relief from itching and exudation in a high percentage of cases. We observed a low toxicity, an absence of side-effects and a marked antipermeability action.

Sandostene should be further studied, for it gives promise of becoming a most useful dermatologic preparation.

478 Peachtree Street

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"Doctors Must Answer"

Gov. James F. Byrnes, speaking at a meeting of the South Carolina Medical Association—"Doctors must answer the misrepresentations of their critics. And the doctors of the state cannot hold themselves aloof from the life of the com-

munity and the state. They must, like all other citizens, take an interest in city, county, and state governments. They have great power and influence, and they should exercise it for their own good and the good of the people."

abstracts by georgia authors



Bennett, Truett, 144 Ponce de Leon Ave., N.E., Atlanta, Ga. "Early Management of Maxillofacial Injuries," Bull. Fulton Co. Med. Soc. 28:13, 15, 39-41, 43-44 (Dec.) 1954.

Careful evaluation of all facial injuries is important to prevent later deformities. A complete examination consists of testing for (1) facial nerve injury, (2) diplopia, (3) malocclusion, (4) mobility of upper jaw, (5) trismus and (6) rhinorrhea or otorrhea. X-rays should be obtained when indicated.

In repairing soft tissue wounds, cleansing of all dirt particles, minimal debridement, careful approximation with small suture and primary closure when possible are all important points in prevention of unnecessary scarring.

Fractured noses require treatment if there is deformity. Simple elevation by an instrument inserted intranasally and molding of the fragments to the mid-line is satisfactory in most instances.

Reduction of fractures of the zygoma and maxilla is necessary if there is deformity, diplopia, difficulty in opening the mouth, or malocclusion. In fractures of the frontal sinus, elevation of the depressed fragments is necessary. Exploration is mandatory if there is a question of depression of the posterior plate. If rhinorrhea is present, nasal packs are to be avoided and the patient placed on antibiotics.

Mandible fractures are manifested by malocclusion. Treatment is designed to re-establish and maintain occlusion and may be done by use of interdental wiring, arch bar splints or open reduction, depending on circumstances.

Chambers, William R., 101 Third St., N.E., Atlanta, Ga. "Hydrocephalus Consequent to Cranium Bifidum," AMA Am. J. Dis. Child. 88:466-470 (Oct.) 1954.

The occurrence of hydrocephalus with cranium bifidum has not enjoyed the logical explanation which the Arnold-Chiari affords the hydrocephalus consequent to spina bifida. The associated congenital anomalies to which it has been ascribed are of too infrequent occurrence to account for all cases.

Enlargement of the head, it is suspected, has sometimes been held synonymous with hydrocephalus, and a case is described which may point up the fallacy of such a course. An infant who had had a frontal cranium bifidum with meningocele removed at two days of age at the skull level began to show signs of rapidly enlarging head. Craniotomy showed a tumor, attached to the stalk, lying intracranially between the cerebral hemispheres. It was a hemangioma. Cases available to the author were reviewed, and two more in which the same type of occurrence should have been suspected were found.

Since tumor underlying spina bifida is not an unusual occurrence, the inference is drawn that all cases of cranium bifidum in which enlarging head occurs should be investigated for the possibility of intracranial tumor.

Cooper, Gerald R. and Mandel, Emanuel E., Box 3242, Grady Memorial Hospital, Atlanta, Ga. "Paper Electrophoresis with Automatic Scanning and Recording," J. Lab. & Clin. Med. 44: 636-643 (Oct.) 1954.

A new electrophoretic apparatus has been developed to study host reaction changes in serum proteins to various diseases. A horizontal bridge paper electrophoresis instrument permitting multiple determinations of protein fractions and other blood components was built with simple and inexpensive equipment to use minute amounts of test material. A continuous scanning and automatic recording instrument was devised for analysis of the stained paper electrophoresis patterns.

Electrophoretic values upon 12 normal sera were established by the standard moving boundary techniques (Tiselius). Results obtained from paper electrophoresis using these same sera were compared with the original standard values and were found to show only small differences and to agree with differences inherent in the respective mechanisms of analysis.

The high degree of reproductibility of results and the rapidity and ease of operation experienced by both the simple paper electrophoresis and the scanning-recording

equipment render it suitable for routine quantitative measurements in the clinical laboratory as well as in the research institute.

King, James T., Medical Arts Bldg., Atlanta, Ga. "Laryngeal Paralysis Associated with Menarche," AMA Arch. Otolaryng. 60:618 (Nov.) 1954.

A white girl, aged 13, complained of hoarseness and voice weakness for two months. Being a member of her church choir, her symptoms were particularly bothersome. The onset of symptoms occurred on the third day of her first menstrual period; the first three days of menstruation had been accompanied by swelling over her body especially in the neck, left arm and shoulder.

Mirror examination of her larynx revealed the intrinsic muscles of the left side of the larynx to be immobile and the left true vocal cord in the position of adduction. Complete physical examination, roentgenograms of the chest and routine laboratory procedures were all normal. No treatment was given, and she was instructed to return for reexamination.

Six weeks later the left cord was in the cadaveric position, and she was noticeably worse. However, after another month, the left cord had returned to the position of adduction, and slight movement was detected on the affected side. When last seen laryngeal movements were entirely normal, and her singing voice was as strong and clear as before her illness.

Leigh, Ted F., Abbott, Osler A., Rogers, James V., Jr. and Gay, Brit B., Jr., Emory University School of Medicine, Emory University, Ga. "Venous Aneurysms," Radiology 63:696-705 (Nov.) 1954.

The authors present four cases of aneurysms arising in venous structures in the mediastinum.

Case I is a congenital aneurysm of the superior vena cava; at operation this was found to be unassociated with any other abnormalities of cardiovascular structures.

Case II is an aneurysm of the superior vena cava, resulting from an anomalous insertion of all the pulmonary veins. The pulmonary veins, rather than entering the left atrium, join to form a vertical vein which ascends on the left side of the mediastinum and enters the left innominate; the left innominate in turn enters the superior vena cava, and this results in marked aneurysmal dilatation because of the extra load of blood. The patient also had an interatrial septal defect, which was the only communication between the right and left side of the heart. The authors point out that this anomaly gives a figure-of-eight configuration to the mediastinum, which is quite characteristic.

Case III is an aneurysm of the hemiazygos vein associated with portal hypertension.

Case IV is an aneurysm of the azygos vein associated with hypoplasia of the inferior vena cava, and cor biloculare combined with pulmonary stenosis.

The article includes nine roentgenograms, one operative photograph and three sketches.

Victor, Irving, 228 East Huntingdon Street, Savannah, Ga. "Innocuous Effects of Intravenously Administered Distilled Water," J. Urol. (June) 1954.

Two cases are presented with inadvertently received intravenous distilled water. Neither sustained any harmful effects. One case was that of a postoperative salpingo-oophorectomy at which time a ureter had been traumatized and a ureteroneocystostomy had been performed. On the first post-operative day the patient received two litres of distilled water and other than a transient hemoglobinuria no harmful after-effects were sustained. The second case was a case of sickle cell anemia with hematuria that received a litre of water for six consecutive days, following which the hematuria ceased and the N.P.N. determination, which had been elevated, returned to normal. It was not proposed that the distilled water was responsible for the improvement in case number two. A brief discussion of the theories concerning intravascular hemolysis as a result of intravenous hypotonic solutions is made. No definite conclusions are drawn but the author suggests further study might elucidate a very fascinating problem.



doctor placement page

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AVAILABLE PHYSICIANS

Berry, Bradley, D., M.D., Whitfield, Mississippi—Age 35; married; Methodist; graduate Jefferson Medical College, Philadelphia, Pennsylvania, 1953; completed internship; interested in general practice in Georgia in community under 10,000; available one month after notified.

Brooking, Donald W. G., M.D., 228 Finley Drive, Decatur, Alabama—Age 33; married; Protestant; graduate University of Minnesota, 1948; residency Brooke Army Hospital and Cornell University Medical College; passed examinations for certification by American Board of Dermatology and Syphilology; interested in dermatology in a clinic, as assistant or associate or industrial; available immediately.

Bryant, Milton F., Jr., M.D., 8166 USA Hospital, APO 547, San Francisco, California—Age 29; married; Protestant; graduate University of Michigan, 1948; residency University of Michigan Hospital; certified by American Board of Surgery; in service at present; specialty general surgery; available August 1955.

Clark, James H., M.D., Butler, Alabama—Age 32; married; Baptist; graduate University of Tennessee, 1946; recently in practice; desires location with better hospital facilities; interested in general practice.

Collins, Douglas, M.D., 172 Riverside Park, Iowa City, Iowa—Age 33; married; Methodist; graduate University of Alabama School of Medicine, 1951; residency State University of Iowa Hospital; specialty Ob-Gyn; available July 1, 1955.

Crupie, Joseph E., M.D., 347 Plant Street, Apt. 4-F, Tampa, Florida—Age 30; married; graduate University of Tennessee College of Medicine, 1953; Priority IV; interested in general practice in Georgia; available first week in February 1955.

German, Walter A., Jr., M.D., 1934 Shoup Court, Apt. 2, Decatur, Georgia—Age 30; married; Methodist; graduate Washington University School of Medicine, 1951; residency Grady Memorial Hospital; specialty ob-gyn; desires associateship; available July 1, 1955.

Gianoulis, James T., M.D., 611 West Grace Street, Richmond 20, Virginia—Age 38; married; graduate Medical School of Virginia, 1941; interested in general surgery and gynecology; Priority IV; six year surgical residence at Medical College of Virginia Hospital; looking for permanent location with a future.

Hunter, I. H., M.D., 204 East Hill Avenue, Valdosta, Georgia—Age 73; married; Missionary Baptist; graduate Grant University, Chattanooga, Tennessee, 1903; interested in general practice; specialty pediatrics; prefers community of 1,000; will accept good position with clinic; been in active practice for 50 years.

Jerius, Diab H., M.D., 18218 Appline Street, Detroit, Michigan—Age 51; single; Protestant; graduate Lausanne University; Switzerland, 1935; residency Sinai Hospital, Detroit; interested in general practice in Georgia as an associate; available immediately.

MacKavanaugh, James L., M.D., 160 Marion Avenue, Merrick, L. I., New York—Age 45; married; Roman Catholic; graduate Georgetown University Medical School, 1934; presently in general practice; wishes to relocate; Priority III; interested in general practice in Georgia, size not too important; available within two to three months after location is selected.

McConnell, Ben H., M.D., Box 664, Beltsville, Maryland—Age 36; married; Episcopal; graduate Georgetown University, 1950; interested in general practice as student health physician with any school, college or university; available at once.

Marder, Leon, M.D., 323 East Chestnut Street, Louisville 2, Kentucky—Age 32; married; Hebrew; graduate University of Oklahoma, 1949; USAF reserve; residency St. Johns General and Michael Reese Hospitals; specialty internal medicine; wishes to associate or share office space with another physician or enter private practice in a community where vacancies exist; available July 1, 1955.

Matousek, Wm. Chas., M.D., 9766 TU, Camp Detrick, Maryland—Age 31; married; Protestant; graduate University of Illinois, 1948; residency Walter Reed Army Hospital; passed Part I of the American Board of Internal Medicine; take Part II in May; available July 1955.

Hohr, Alzon J., M.D., Tremonton, Utah—Age 40; desires rural area where one may raise a family in pleasant surroundings; preferably near a hospital; served in Army during World War II; been practicing in Utah since 1945; graduate Northwestern University; 10 years as a general practitioner; available immediately.

Peake, Charles O., M.D., 884½ 9th Avenue S.E., Rochester, Minnesota—Age 27; married; graduate University of Pennsylvania 1951; internship Evanston Hospital; residency Mayo Foundation; Priority IV; specialty ob-gyn; prefers community of 50,000 or over; interested in locating in Georgia, particularly Atlanta, in clinic, as assistant or associate; available July 1, 1955.

Scruggs, W. H., M.D., Bryson City, North Carolina—Age 65; limited general practice; licensed in Georgia; married; Baptist; graduate University of Maryland, 1913; prefers small town with hospital; available anytime during next three months.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland—Age 30; married; Roman Catholic; graduate Georgetown University 1948; residency USN Hospital, Bethesda, Maryland; Priority IV; specialty internal medicine; prefers community in Georgia of 20,000 to 30,000; available June 1955.

Shannon, Lloyd W., M.D., 1234 Henleaze Avenue, Moose Jaw, Saskatchewan, Canada—Age 31; married; Presbyterian; graduate University of Manitoba, 1947; presently in practice, wishes to relocate because medicine is becoming greatly socialized in Saskatchewan; specialty general surgery; industrial assistant or associate, would consider clinic; available February or March 1955.

Sharp, Thomas B., Jr., M.D., 1530 Shoup Court, Decatur, Georgia—Age 28;

married; Protestant; graduate Emory University, 1950; residency Lawson VA Hospital; Grady Memorial Hospital; military requirements fulfilled; specialty internal medicine; clinic preferred; available July 1, 1955.

Smith, Fred C., M.D., Emory University Hospital, Emory University, Georgia—Age 32; married; Baptist; graduate Emory University School of Medicine, 1950; residency Atlanta VA Hospital (3 years), Emory University Hospital (1 year), holds Georgia license; eligible to take American Board of Surgery exam after June 1955; Priority IV; specialty general surgery; available July 1, 1955.

Watson, Alfred Lawrence, M.D., 1415 Titus Road, Memphis 11, Tennessee—Age 29; married; Methodist; graduate Vanderbilt University School of Medicine, 1949; residency Grady Hospital and Kennedy VA Hospital, Tennessee; Priority IV; specialty internal medicine; available July 1, 1955.

Young, E. Reynolds, M.D., Philadelphia General Hospital, 34th Street and Curie Ave., Philadelphia, Pennsylvania—graduate Vanderbilt University School of Medicine, 1954; internship at Philadelphia General Hospital will be completed in July; interested in general practice; prefers to assist or associate with practitioner already established.

AVAILABLE LOCATIONS

Arlington, Georgia (Calhoun County)—Population 1,382. In need of doctor-surgeon for practice in new excellently equipped 16-bed hospital, located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia.

Atlanta, Georgia (Fulton County)—Want an assistant in Industrial Surgery; one year rotating internship is only requirement as to training. Hours 9 a.m. to 5 p.m. except Saturday—9 a.m. to 1 p.m. No night calls, no weekend calls. Sorry, \$750.00 month to start. Contact MAG Headquarters Office, 875 West Peachtree St., Atlanta.

Bremen, Georgia (Haralson County)—Population 3,500. Need an associate in field of obstetrics and gynecology. Completing a modern office building to house the group and new 20 bed hospital is in operation. Group consists of three physicians—two in surgery and one in medicine and anesthesia. Would have all the work he could handle. Contact Dr. J. H. Pritchett, Jr., Bremen, Georgia.

Dillard, Georgia (Rabun County)—Population 2,500. Doctor's office to be furnished rent free for one year; would rent five or six room house, fully equipped kitchen, county hospital at Clayton; drug store and pharmacist; good schools; doctor would be welcome right now; late doctor had an excellent practice; other benefits considered in a short time; active church groups and community club that would be happy to assist doctor. Contact: Mrs. L. Neville, Dillard, Georgia.

Edison, Georgia (Calhoun County)—Population 1,245. Two physicians in area; Hill-Burton Hospital (1 mi.); one clinic local with 10 beds, x-ray, lab equipment, operating room with instruments; rental \$75.00 (maximum \$100.00) per month;

two excellent drug stores; housing available for rent at \$30-\$40; good elementary and high schools; five churches; great need for a physician in this community. Contact: Dr. J. S. Beard, Edison, Georgia.

Jeffersonville, Georgia (Twiggs County)—Population 1,000. Only doctor in county is in his 70's and has been doing a limited practice. Contact: Mr. H. C. Swearingen, Jeffersonville, Georgia.

Marietta, Georgia (Cobb County)—Population 10,000. Interested in Negro physician to replace present physician who is going into Armed Forces in approximately six months. Contact: Mr. M. L. Wear, Administrator, Kennestone Hospital, Marietta, Georgia.

Roswell, Georgia (Fulton County)—Population 2,500. Two physicians in area, ages 73 to 40; hospital facilities in Atlanta; nice office space available rent free; housing can be arranged; very good opportunity for physician who wants plenty of practice; one of the physicians has been out sick for about two months; section is growing rapidly. Contact: Roswell Lions Club, Roswell, Georgia.

Winder, Georgia (Barrow County)—Population 6,000. Eight physicians in area; four active, two part time and two inactive; 40 bed Hill-Burton Hospital in city limits—completely equipped; office space available; three active drug stores; interested in obtaining services of two or three young physicians who want to do

general practice; feel that area has much to offer with a good sound economy, ideal location, adequate hospital facilities and a crying need for well trained interested men; contact, by phone, mail or in person for any further information, Dr. C. B. Skelton, Peoples Bank Bldg., Winder. (Office Phone 3851).

Woodbine, Georgia (Camden County)—Population 1,000. Small, fully equipped office and clinic available; ample office space, delivery room, laboratory (inc. x-ray), nursery, wards, private rooms; five room wooden dwelling adjoins hospital available at \$35.00 mo.; one other doctor in Woodbine, doctor is needed now. Contact: Dr. S. C. Atkinson, Waverley, Ga.

"FIRST COME, FIRST SERVE"

... That's the way Hotel Reservations will be handled for the 1955 Annual Session of the Medical Association of Georgia, May 1-4, at the Bon Air Hotel, Augusta.

IF YOU WANT A ROOM WRITE IMMEDIATELY TO:

Dr. David R. Thomas Jr., Chairman, MAG Hotel Reservations Committee, Bon Air Hotel, Augusta



NOTE:

1. The Bon Air Hotel will confirm reservations until the 250 available rooms are filled.
2. After the Bon Air is filled, your reservation will be confirmed direct by the Partridge Inn or the Richmond Hotel.



REMEMBER — FIRST COME, FIRST SERVE

Make your reservation now!

Public Relations Committee

December 12, 1954

The Public Relations Committee of the Medical Association of Georgia was called to order by Chairman Chris McLoughlin at a meeting held December 12, 1954, Dempsey Hotel.

Members of the committee present were: Peter L. Scardino, 1st District; George R. Dillinger, 2nd District; Virgil Williams, 4th District; J. Lamont Henry, 5th District; Warren M. Gilbert, 7th District; Sage Harper, 8th District; Eugene Ward, 9th District; David Henry Poer, MAG Secretary-Treasurer and the Chairman.

It was moved and duly seconded that the minutes of the meeting held in Macon on July 12th, 1953, be adopted as published in the *Journal of the Medical Association of Georgia*, August 1953, and the motion carried.

The chairman called on Mr. Milton D. Krueger, MAG Executive Secretary, for a report on problems involved in presenting the Public Relations program to the 80 component societies of the Association. Mr. Krueger stated that progress had been made with some 50 societies, but at that time approximately 25 to 30 societies were inactive. He reported that the Association considered activation of the 30 societies the first order of business, and he felt that any efforts by the committee along these lines would best serve the committee so that they might then better present their program. He further reported that Council, cognizant of this problem, had recommended certain minimum standards for society status as follows:

(1) That each county medical society meet a minimum of four times a year, elect officers and delegates annually and so report to the Headquarters Office.

(2) That each county medical society have a constitution and by-laws.

(3) That each county medical society have a Board of Censors and/or a Grievance (Mediation) Committee.

(4) That each county medical society secretary record the minutes of each meeting in a permanent record book that will be available at all times, and

(5) That each county medical society, at its minimum four meetings annually, have planned

scientific programs.

Mr. Krueger stated that because of the inactivity of these 30 societies any program as proposed by any of the 40 MAG committees could at best be only three-fourths successful as far as component society cooperation. In closing his remarks, he again emphasized that "public relations begins at home" and that the committee should give full consideration to this problem facing the Association.

Chairman McLoughlin then outlined a public relations approach to this same problem. Dr. McLoughlin felt that the solution of this society inactivity could best be met on the district level. He stated that rather than have a statewide county society presidents' and secretaries' conference, he would prefer "putting the show on the road" and holding these conferences at the grass roots level. This could be done, he said, by holding these conferences for each of the 10 districts—much like a district society meeting—but limiting the attendance to presidents and secretaries of the 12 to 15 societies in each district. By so doing, the presentation and discussion could better pertain to each of the societies within the district.

Chairman McLoughlin's tentative program for these conferences was discussed as follows:

(1) AMA movie on "AMA Activities in the Physician's Behalf."

(2) Background of what makes up a good county medical society.

(3) Data on the present status of societies within district.

(4) Purposes of county medical society and minimum standards for county medical societies as recommended by MAG Council.

(5) Public relations aspect of society activity (basic eight points).

(6) Woman's auxiliary and the county society.

General approval of the plans were given the chairman by the committee.

Final item of business discussed was the planning for public relations at the Association's Annual Session, Bon Air Hotel, Augusta, May 1-4, 1955. The Local Arrangements public relations chairman discussed the present plans for a social hour for members of the press, radio and TV in Augusta about three weeks prior to the Session. Also discussed was the employment of a public relations counsel in Augusta to handle the press, radio and TV arrangements during the Session itself.

Upon completion of this discussion, the meeting was adjourned.

Public Health Committee

January 16, 1954

At a meeting of the Public Health Committee held at 2 p.m., Sunday, January 16th, Academy of Medicine, the following members were present: T. A. Sappington, Chairman, Thomaston; R. F. Spanjer, Cedartown; and T. F. Sellers, Atlanta. Invited to attend the meeting for reorganizational purposes were the following MAG Committee Chairmen: Duncan Shepard, Industrial Health, Atlanta; George Nicholson, Cornelia, Rural Health; Edgar Dunstan, Atlanta, Medical Civil Preparedness; J. C. Hughston, Columbus, Georgia Society for Crippled Children; Peter Hydrick, College Park, Maternal and Infant Welfare; and L. Minor Blackford, Atlanta, Chronic Illness. Also in attendance from the State Department of Public Health were the following members: John R. Venable, Atlanta; R. C. Williams, Atlanta; S. C. Rutland, Atlanta; and Lester M. Petrie, Atlanta. In addition, in attendance were Helen Bellhouse, Atlanta, Secretary of the Maternal and Infant Welfare Committee; David Henry Poer, Association Secretary, and Mr. Milton D. Krueger.

Chairman Sappington called the meeting to order at 2:10 p.m. After introducing all of the physicians in attendance, Chairman Sappington commented on the purpose of the meeting.

Chairman Sappington read from the MAG Constitution and By-Laws the structure and purpose of the Public Health Committee. He then proposed that the Public Health Committee have delegated to it matters that crossed other Association committee lines; he stated that he believed that the MAG Public Health Committee should serve as a clearing house and that the committee should concentrate its activity on correlating public health problems within the other committees.

Chairman Sappington explained that he believed it to be in the best interest to have the Public Health Committee composed of a chairman and a member of the Georgia State Department of Health (appointed by the Association President annually). He further proposed that the rest of the committee should be made up of Association committee chairmen whose committees were concerned with some portion of the broad term Public Health Committee. He stated this then would keep the Public Health Committee out of the realm of other committees and prevent the overlapping of activities by these other Association committees and would allow the Public

Health Committee to be a clearing house of the other committees' activities. He suggested that the Public Health Committee meet at least annually right after committee appointments were made by the incoming president to report on each of the other committees' projects and program and correlate their activities.

Each member of the other Association committees commented on this plan, and all the other committee chairmen present were in favor of Chairman Sappington's plan.

After this unanimous approval of Dr. Sappington's plan, he instructed the executive secretary to draw up a revision of the present MAG Constitution and By-Laws relative to the structure and function of the Public Health Committee and transmit this to J. W. Chambers, Chairman of the MAG Constitution and By-Laws Committee, for action by the House of Delegates.

The new structure and function of the Public Health Committee would then be as follows:

"By-Laws. Chapter IX. Section G. THE COMMITTEE ON PUBLIC HEALTH. The Committee on Public Health shall be composed of a chairman and a member of the Georgia State Department of Health appointed by the president of the Medical Association of Georgia and the chairman of each of the following Association committees: Industrial Health; Rural Health; Hospitals; Legislation; Medical Civil Preparedness; Mental Health; Crippled Children; Maternal and Infant Welfare; Chronic Illness; Cancer; Insurance Board; and Blood Banks. The chairmen of these committees shall then automatically be members of the Association's Public Health Committee and shall select an alternate member from each of their respective committees to represent them at Public Health Committee meetings in the absence of the chairman. It shall be the duty of the Public Health Committee to meet at least annually to hear reports from the committee chairmen members so named, to correlate their activities and to act as a "clearing house" for any matters concerning public health. It shall also be the duty of the Public Health Committee to correlate these activities with the Georgia Department of Public Health."

Chairman Sappington then called for reports from the committee chairmen present for informational purposes only.

Chairman Shepard, Industrial Health Committee, reported on the following projects undertaken by his committee: (1) revision of workmen's compensation laws by legislation and (2)

liaison between the MAG Industrial Health Committee and Insurance Carriers.

Chairman Nicholson, Rural Health Committee, reported on the following projects undertaken by the Rural Health Committee: (1) physicians placement; (2) public education for utilization of medical facilities existent in rural areas; (3) home and farm accident prevention; (4) standard immunization program for the State; (5) improved mental health care for rural areas; (6) recruitment of paramedical personnel for rural areas; (7) county medical society visitation program to disseminate and educate physicians on rural health problems; (8) State Rural Health Conference after previous projects have been completed and (9) liaison with the farm bureau, 4-H Clubs and other interested groups for improvement of medical care in rural areas.

R. C. Williams reported on a visit with Chairman Seamans, Hospitals Committee, at which six or eight projects for the Hospitals Committee were discussed. A few of these projects were hospital accreditation; hospital medical staff organization; refresher work for hospital technicians, etc.

Mr. Krueger reported on a recent meeting of Chairman Coker's Legislation Committee at which the following legislation was discussed: (1) new osteopath amendment, (2) creation of a state agency for the visually handicapped, (3) rabies bill, (4) hospital construction bill, (5) injunction law, (6) workmen's compensation revision legislation, etc.

Chairman Dunstan of the Medical Civil Preparedness Committee reported on Civil Defense General Order 13 which divides the state into areas for organization purposes and affords better coordination. He also reported on the availability within the next four months of a 200 bed portable hospital to be used over the State for

instructional purposes. Another item he discussed was the coordination of civil defense with the Red Cross and the Association.

Chairman Hughston of the Crippled Children's Committee reported on the national program for a gradual amalgamation of all crippled children's facilities in Georgia. He stated that they must go slowly in this amalgamation so as not to violate organizational autonomy.

Chairman Hydrick and Secretary Bellhouse of the Maternal and Infant Welfare Committee reported on their committee's investigation of maternal death using the North Carolina plan. Also included in the investigation is infant mortality. They noted an excellent response to this survey. Dr. Hydrick also mentioned his committee's organization of key men for contacting district and county medical societies with data from his committee such as birth certificate education, etc.

Chairman Blackford, Chronic Illness Committee, is at present working with the State Department of Public Health and the Federal Government on a survey of chronic illness in Georgia as funds are available at the present time.

Dr. Sellers, Director of the State Department of Public Health, reported on certain budgetary inadequacies and gave specific cases for information to the group. He reported that a study committee has been appointed by the Governor to investigate the "real" needs of his department, and this study committee will report in June of 1955.

Association Secretary David Henry Poer commented on the one year term of office of committee chairmen and reported that it was his hope that the term of office of Association committee chairmen would be lengthened to allow a better understanding of committee work gained through experience by the chairmen.

Chairman Sappington adjourned the meeting at 3:45 p.m.

Tuberculosis in Georgia

Last year 1,977 previously unreported cases of tuberculosis were uncovered in the State and 417 persons succumbed to this disease. Despite the gratifying decrease in deaths from tuberculosis during recent years and the marvelous new treatment measures, tuberculosis is still a major problem in Georgia. The encouraging fact that new drugs are available for prolonging the lives of tuberculosis cases poses a growing problem in their care and control.

There are nearly 15,000 cases of tuberculosis in Georgia and more than \$6,500,000 annually is being spent in their care and in the control of this disease. This does not include all the costs of home medical care, drugs, time lost from work, and costs to the general economy by reason of a large number of untimely deaths from tuberculosis. If these expenses were included \$10,000,000 would be a conservative estimate of the cost in Georgia.

ANNOUNCEMENTS

Physician Pilots—A national organization of physician pilots is being formed whose purpose is scientific, educational and social. Physician pilots interested are requested to send their names, plane flown and landing field used to the local chairman of their area, or, if not known, to H. D. Vickers, M. D., 25 Jackson Street, Little Falls, New York, Temporary Chairman.

Society for the Prevention of Asphyxial Death, Inc. Meeting—March 24, 1955, New York Academy of Sciences. Admission to the meeting will be by card; please address Secretary, S. P. A. D., Inc., 2 East 63rd Street, New York 21, N. Y., stating "Admission card requested".

Gill Memorial Eye, Ear, and Throat Hospital 28th Annual Spring Congress—April 4 to 9, 1955, Roanoke, Virginia. For further information address Dr. E. G. Gill, 711 South Jefferson Street, Roanoke, Va.

American Goiter Association Meeting—April 28, 29 and 30, 1955, Skirvin Hotel, Oklahoma City, Okla. For information write Dr. John C. McClintock, Secretary, American Goiter Association, 149½ Washington Ave., Albany, N. Y.

Georgia Heart Association Annual Award—\$100 will be awarded to intern, house officer or fellow in Georgia Hospital, or physician in Georgia who has practiced five years or less for best paper presented to the Association on any subject in the field of cardiovascular diseases. For information contact the Georgia Heart Association, 318 Western Union Bldg., Atlanta 3, Ga.

Short Course in the Clinical Pathology and Pathology of Parasitic Diseases—August 15-17, 1955, Louisiana State University School of Medicine, New Orleans, La. The fee for the course is \$50.00. For further information write to Dr. Clyde Swartzwelder, Dept. of Microbiology, L. S. U. School of Medicine, 1542 Tulane Ave., New Orleans 12, La.

American Congress of Physical Medicine and Rehabilitation Annual Essay Award—The contest is open to anyone; the winner shall receive a cash award of \$200, a gold medal, certificate of award and an invitation to present the paper at the 33rd Annual Session of the American Congress of Physical Medicine and Rehabilitation (see below). All inquiries should be addressed to the American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Ill.

American Congress of Physical Medicine and Rehabilitation 33rd Annual Session—August 28-September 2, 1955, Hotel Statler, Detroit, Michigan. Open to all members of the A. M. A. For full information write to Dorothea C. Augustin, 30 North Michigan Avenue, Chicago 2, Illinois.

International Academy of Proctology 7th Annual Meeting—March 23-26, 1955, Hotel Plaza, New York City. For further information contact Beverly Hill, Harold Wolff & Associates, 11 East 47th Street, New York, N. Y.

American College of Surgeons Sectional Meeting—April 4-6, 1955, Nashville, Tennessee. For further information write to the American College of Surgeons, 40 East Erie Street, Chicago 11, Ill.

International College of Surgeons Scholarship—\$3,000 scholarship to be awarded to American or Canadian Surgeon for study abroad. Recipient will be expected to spend at least 10 months of the year as a resident or fellow in a teaching center in one of the countries of Europe or South America. For details, address The Scholarship Committee, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

American Society of Plastic and Reconstructive Surgery 1955 Scholarship Contest—Deadline for all entries is July 1, 1955. For further information write to the Award Committee, c/o The Foundation of the American Society of Plastic and Reconstructive Surgery, Inc., 30 Central Park South, New York 19, N. Y.

Recent Advances in the Study of Venereal Diseases 7th Annual Symposium—April 28 and 29, 1955, Department of Health, Education and Welfare, Washington, D. C.

SOCIETIES

The regular monthly meeting of the BURKE COUNTY, JENKINS COUNTY and SCREVEN COUNTY MEDICAL SOCIETIES was held in Waynesboro on January 7th. Peter B. Wright, Augusta, President of the Medical Association of Georgia, T. H. Harper, Jr., Augusta, and Louis O. J. Manganiello, Augusta, were guests at this meeting. Dr. Wright spoke on fractures of the wrist, and Dr. Harper, on arrhythmia of the heart.

The GEORGIA MEDICAL SOCIETY met in Savannah at the Society's Hall on January 11th. Herman Delancy read a paper on "Radical Surgery in Gastro-Intestinal Cancer". Howard J. Morrison presented a case report on "Cat Scratch Disease in a Six Year Old Boy".

COLQUITT COUNTY MEDICAL SOCIETY met in Moultrie on January 11th. Officers elected at this meeting were as follows: John McLeod, president; Edgar Holmes, vice-president; and James Flynn, secretary-treasurer. The society went on record in positive support of the campaign to halt so-called "mercy speeding" through Moultrie's streets. They also endorsed a law requiring patients with positive tuberculosis sputum to clear their cases through examination or undergo treatment.

At a recent meeting of the EMANUEL COUNTY MEDICAL SOCIETY, R. G. Brown, Swainsboro, was elected president of the society. C. E. Powell, Swainsboro, was elected vice-president, and Robert Moye, Adrian, was elected secretary-treasurer. Dr. Moye was also named delegate to the Annual Session, with Herbert Frost, alternate.

FULTON COUNTY MEDICAL SOCIETY celebrated 50 years of service to Atlanta at the annual banquet January 6th at the Athletic Club, Atlanta. B. L. Shackleford, president, was master of ceremonies and

presented 25 and 50 year membership certificates. Those doctors who have been members of the society for 50 years are James B. Baird, William T. Bivings, Charles E. Boynton, James N. Brawner, Sr., W. L. Champion, Fred G. Hodgson, G. Pope Huguley, Hugh M. Lokey, W. E. Person, L. C. Rouglin, W. A. Selman, A. H. Van Dyke, S. A. Visanska. Edgar M. Dunstan received the Aven Citizenship cup for distinguished community service in the field of civil defense.

Carl S. Pittman, Sr., Tifton, has been elected president of the TIFT COUNTY MEDICAL SOCIETY. Other officers elected to serve in 1955 are Tom Edmondson, vice president, and E. M. Flowers, secretary-treasurer.

DEATHS

WILLIAM R. BARNETT, Calhoun, died at a private hospital January 15, 1955, after an illness of six years. Dr. Barnett was 79 years of age at the time of his death. He had retired from active practice in 1948.

Dr. Barnett was born in Dawson County and attended Reinhardt College. He taught school for several years before entering the Medical College of Georgia. He finished his medical training in Chattanooga. Dr. Barnett came to Calhoun in 1922 to set up his practice. He served with the Georgia Public Health Service in World War I.

He was a member of the Masons, Odd Fellows and the Gordon County Medical Society.

Funeral services were held Sunday, January 20, at the Combs Funeral Home Chapel; burial was in Fain Cemetery. Members of the Gordon County Medical Society served as honorary pallbearers.

ANDREW JONES KILPATRICK, Augusta, died unexpectedly at his home in Augusta on January 10, 1955. Dr. Kilpatrick was one of Augusta's most beloved physicians and an outstanding obstetrician.

He was a native of Hephzibah and received his M.D. degree from the Medical College of Georgia in 1896. Dr. Kilpatrick had been in practice in Augusta since that time until a few years ago when he retired from active practice. He served as clinical professor of obstetrics at the Medical College, and was made clinical professor emeritus on his retirement.

His main interest centered around his profession, but he was also an avid sportsman. A hunter and fisherman of note, he went fox hunting almost weekly until the time of his death.

Graveside services for Dr. Kilpatrick were held on January 11th; among the pallbearers were J. W. Thurmond, Thomas Goodwin, G. T. Bernard, Dewey Gray, W. K. Philpot, Richard Weeks and A. A. Walden.

Dr. Kilpatrick is survived by two sons, Mr. A. J. Kilpatrick, Jr., and Charles M. Kilpatrick, both of Augusta.

ROBERT JOHN WESTBROOK, Ila, 77, died at his home on January 3, 1955, following an illness of three weeks.

Dr. Westbrook was a native of Franklin County and had lived in Ila for 64 years. He was educated in the Ila schools and received his medical degree from the Medical College of Georgia.

Funeral services were held at the Ila Presbyterian Church with burial in the church cemetery. Dr. Westbrook is survived by his wife, Mrs. Desdemona Westbrook, four daughters and three sons.

ROBERT L. WHIPPLE, Cochran, 81, died of a heart attack in his office on December 28, 1954. He is survived by his wife and one son, Robert L. Whipple, Jr., Atlanta.

A native of Laurens County, Dr. Whipple moved to Cochran at the age of 12 and had practiced in Cochran for almost 60 years. He was one of the three oldest living graduates of the Southern Medical College, now Emory University School of Medicine. Dr. Whipple was featured in an article entitled "The Old Grad . . ." in the September issue of this *Journal*—the special Emory issue. Besides keeping up an active medical practice, Dr. Whipple was president of the Cochran Oil Mill, a director of the State Bank there and a deacon in the First Baptist Church.

Funeral services were held December 30, 1954, at the First Baptist Church of Cochran. Members of the Tri-County Medical Society served as honorary pallbearers.

JOHN D. WILEY, Milledgeville, 54, died December 24, 1954, after suffering a heart attack at his home in Milledgeville.

Dr. Wiley was a native of Sparta and had been on the staff of the Milledgeville State Hospital for 28 years.

Funeral services were held at the graveside in the City Cemetery of Sparta on December 25th.

Surviving are his wife, the former Miss Frances Reese, and one son, Mr. Robert C. Wiley, II, a student at the University of Georgia.

PERSONALS

JOHN T. AKIN, JR., Atlanta, announces the removal of his office to Suite 716, Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E., for the practice of general surgery.

HERBERT S. ALDEN, Atlanta, announces the removal of his office to Suite 600, Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E., with practice limited to dermatology.

SAMUEL S. AMBROSE, C. S. BUCHANAN and SIDNEY OLANSKY, all of Atlanta, were on the instructional staff of the 23rd V. D. Postgraduate Conference sponsored by the U. S. Public Health Service which was held in New Orleans, January 31 to February 4, 1955.

THOMAS J. ANDERSON, JR., Atlanta, announces the removal of his office to 501 Doctors Building, 478 Peachtree Street, N.E., with practice limited to internal medicine and gastroenterology.

CARL C. AVEN, Atlanta, spoke at a recent meeting

sponsored by the Sandy Springs Woman's Club which is currently conducting a six months drive to present the facts about tuberculosis to the public. His topic was "A New Look at the Tuberculosis Problem." JOSEPH S. CRUISE, Atlanta, will be the speaker at the Club's March meeting.

J. MASON BAIRD and HARRY D. ARNOLD, JR., Atlanta, announce their new office location: Suite 235 Strickler Building, 1293 Peachtree Street, N.E.

E. D. BELL, Douglas, has accepted a residency in surgery at St. Elizabeth's Hospital in LaFayette, Indiana. Dr. Bell plans to return to Douglas upon completion of his training at St. Elizabeth's.

JAMES BENNETT, Augusta, spoke to the Augusta Exchange Club recently on the new strides that have been taken by the medical profession to fight and eliminate polio.

WILLIAM H. BENNETT, Atlanta, announces the removal of his offices from the Medical Arts Building to the Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E., Suite 701, with practice limited to urology.

LINTON H. BISHOP, JR., Atlanta, announces the removal of his office to 501 Doctors Building, 478 Peachtree Street, N.E., with practice limited to internal medicine and cardiology.

SAMUEL U. BRALY and JOE I. MATTHEWS, Dallas, announce the opening of Paulding County Hospital, formerly Matthews Hospital. CHARLES T. HENDERSON, Marietta, will be the visiting consultant in surgery. Complete operating room and delivery room facilities are available, as are x-ray and laboratory facilities. The doctors' offices will be on the lower floor of the building.

WALTER BRAMBLETT, Forsyth, was moderator of a panel discussion held January 25th in Forsyth. The subject of the discussion was "Psychosomatic Medicine"; other physicians participating on the panel were DARRELL HAZELHURST, SHANNON MAYS and T. M. HALL, Macon.

O. C. BRANNEN, Columbus, has been appointed to the State Board of Health by Governor Marvin Griffin.

Three Georgia doctors are among the 19 pediatricians named to study the effects of the drug Isoniazid on the prevention of tubercular meningitis in children. They are J. C. BURCH, Fulton County Health Department; GEORGE W. COMSTOCK, Muscogee County Health Department; and RUFUS PAYNE, Eugene Talmadge Memorial Hospital, Augusta.

TAYLOR S. BURGESS, Atlanta, announces the removal of his office to the Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E., for the practice of otolaryngology.

E. L. BUTTS, Augusta, has announced the reopening of his Louisville office for consultation on Saturday of each week.

T. LUTHER BYRD, Atlanta, announces the removal

of his offices to Suite 325 North Wing of the Doctors Building, 490 Peachtree Street, N.E., and his association with A. WORTH HOBBY in the practice of internal medicine and diseases of the chest.

In the January-February issue of *Children, A Professional Journal on Services for Children and on Child Life*, an article by Eleanor P. Hunt, Ph.D., entitled, "Getting at the Facts of Infant Losses," quotes facts and figures on the state of Georgia. Credit is given to HELEN BELLHOUSE, Atlanta, for furnishing this special material.

SANDY CARTER, Atlanta, announces the removal of his office to 218 Strickler Building, 1293 Peachtree Street, N.E.

ROBERT EUGENE CATO, Macon, who recently moved to Macon from Savannah has opened an office at 763 Pine Street for the practice of radiology. He is also roentgenologist at Parkview Hospital. Dr. Cato received a B.A. degree from Emory University and his M.D. from the Emory University School of Medicine; he received his radiology training at University Hospital in Baltimore, Md., and Grady Memorial Hospital in Atlanta. He was certified by the American Board of Radiology in 1954.

RIVES CHALMERS, Atlanta, announces the removal of his office to Suite 631, Cyrus W. Strickler Sr. Doctors Building, 1293 Peachtree Street, N.E., with practice limited to psychiatry.

JOHN L. CHANDLER, Augusta, and EDGAR WOODY, JR., Atlanta, attended the Fourth Annual Meeting of the A.M.E.F. State Chairmen, held in Chicago at the Sheraton Hotel on January 23rd. The meeting opened the 1955 campaign for funds for the Foundation. Dr. Woody also visited the offices of the *A.M.A. Journal*.

N. HAMPTON CHILES and L. GUY CHELTON, Atlanta, announce the opening of offices for the practice of internal medicine in the Strickler Building, 1293 Peachtree Street, N.E.

ELLISON R. COOK, III, Savannah, recently participated in a panel discussion whose topic was "What should we tell children about sex?" at the annual meeting of the Savannah-Chatham County Mental Health Association.

The following doctors recently passed the exams for certification by the American Board of Surgery: GUY DAVIS, JOSEPH S. ROBINSON, JOHN SHELLACK, IRVING GREENBERG, all of Atlanta, and CHARLES HENDERSON, Marietta.

JOE DENTON COMBS, formerly of Milledgeville, has recently become associated with JOSEPH D. McELROY, JOSEPH S. SKOBBA and PAUL L. SCHROEDER in the practice of psychiatry. Dr. Combs comes from Milledgeville where for the last five years he has been clinical director of the Milledgeville State Hospital. He received his M.A. and Ph.D. degrees from the University of Illinois and his M.D. degree from the Medical College of Georgia where he was assistant professor of neuro-anatomy from 1934

through 1941. He was a fellow of the Menninger Foundation School of Psychiatry, 1949-1950, and a fellow of the Psychiatric Institute of Pennsylvania Hospital in 1951. Dr. Combs' new office location is 153 Doctors Building, 490 Peachtree Street, N.E.

WILLIAM F. DOWDA, Atlanta, announces the opening of his office at 104 Ponce de Leon Avenue, N.E. for the practice of internal medicine.

J. HARRY DUNCAN, Savannah, has been named president of the medical staff of St. Joseph's Hospital. Other officers include: EMERSON HAM, vice president; FENWICK NICHOLS, secretary; and GRANT GOLDENSTAR, treasurer.

ALBERT FISHER, Atlanta, announces the opening of his office for the practice of ophthalmology in the Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E.

MILTON FREEDMAN, Atlanta, has been named a fellow in the International Society of Hematologists.

P. W. GARNER, Austell, and Mrs. Garner were recently the honor guests at a reception given by Dr. and Mrs. J. G. BUSSEY. Some 300 residents of the South Cobb area called at the Bussey home to meet the Garners. Dr. Garner, a general practitioner, graduated from the Medical College of Georgia in 1949; he interned at the Jefferson Hillman Hospital in Birmingham and Charity Hospital in New Orleans. He comes to Austell Hospital from Crawfordsville.

ROBERT B. GOTTSCHALK, Savannah, is the new president of the staff of the Warren A. Candler Hospital. Other officers elected were C. R. A. REDMOND, vice president, and DAVID D. ROBINSON, secretary-treasurer.

J. CANDLER GUY, Atlanta, spent the first two weeks of February at the Mayo Clinic and at the University of Iowa Medical Center having been presented one of the three fellowships awarded by the Southeastern Section of the American Urological Association for two weeks of study at medical centers of the recipient's choice.

THOMAS D. HARDY, Stone Mountain, is the administrative director of the new Stone Mountain General Hospital; other staff members are GEORGE GEIST and AUGUST J. NORDONE. The hospital was formerly known as Stone Mountain Sanitorium.

E. R. JENNINGS, Brunswick, spoke at the January meeting of the Brunswick Business and Professional Woman's Club. He stressed the need of everyone for a family doctor and regular check-ups in the fight against disease. Along with his talk, Dr. Jennings showed a movie of the various stages of cancer.

STERLING H. JERNIGAN, Atlanta, announces the removal of his offices to Suite 7, 710 Peachtree Street, N.E., for the practice of general surgery.

J. B. KAY, Byron, was guest speaker at a recent meeting of the Cordele Kiwanis Club; Georgia's

"Practitioner of the Year" spoke on "The Progress of Medicine in the Past 50 Years." Special guests of the club at this meeting were the members of the Crisp County Medical Society and GEORGE ALEXANDER, of Forsyth, who introduced Dr. Kay.

A. P. KELLER, JR., Athens, was elected president of the medical staff of the Athens General Hospital at a recent meeting of the staff. Elected to serve with him in 1955 are A. H. GALLIS, vice president, and WILLIAM H. BONNER, secretary. Named to the executive committee were R. H. RANDOLPH, H. B. HARRIS and GOODLOE Y. ERWIN.

JAMES T. KING, Atlanta, recently returned from Charlottesville, Virginia, where he read a paper at the Southern Sectional Meeting of the American Rhinological, Laryngological and Otological Society. The title of his paper was, "Headache, Sinusitis and Mother Goose."

F. LANSING LEE, Augusta, announces the removal of his offices to 1433 Gwinnett Street—in front of the University Hospital.

HAROLD B. LEVIN, Atlanta, announces the removal of his office to Suite 212, 1293 Peachtree Street, N.E., with practice limited to the skin.

MERRILL LINEBACK, Atlanta, announces the removal of his office on January 1st to Suite One, 28 Eighth Street, N.E., for the practice of otorhinolaryngology and broncho-esophagology.

J. A. MAXWELL, A. G. LEROY, J. M. GARRISON and HENRY M. ALTHISAR, Thomson, have recently moved into the new Doctors' Building adjacent to the McDuffie County Hospital.

RUTH MCCLURE, Marietta, announces the opening of her office at 301 Cherokee Street for the practice of obstetrics and gynecology. Dr. McClure is a native of Acworth and a graduate of the Emory University School of Medicine. She served a four year residency at Piedmont Hospital, Atlanta, and practiced in Atlanta for two years.

THOMAS A. MCGOLDRICK, JR., Savannah, was the principal speaker at a recent meeting of the Savannah League of Women Voters. He discussed a report on tuberculosis made by a committee, headed by him, which was set up under the auspices of the United Community Service to study the T. B. problem. C. A. HENDERSON, Chatham County Health Officer, introduced the speaker.

THOMAS C. MCPHERSON, Atlanta, announces the removal of his office to Suite 626, Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E.

WILLIAM W. MOORE, Atlanta, announces the removal of his office to Suite 616 of the new Strickler Building, 1293 Peachtree Street, N.E., for the practice of neurological surgery.

Four Atlanta physicians recently formed a panel to discuss the health and care of children. JACK NORRIS was panel moderator; THOMAS C. MCPHERSON discussed pediatrics; children's dentistry was discussed by Vincent M. Johnson, D.D.S.; WILLIAM

R. FISHER discussed eye, ear, nose and throat troubles; and R. BRUCE LOGUE discussed the heart.

HART ODOM, Greenville, has moved to Woodbury where he will enter private practice. He was formerly associated with Gilbert's Clinic in Greenville.

HARRY PARKS, Atlanta, announces the removal of his office to the Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E.

WILLIAM J. PEEPLES, Columbus, has resigned his position as Muscogee County assistant commissioner of health to become health officer of Montgomery County (Baltimore), Maryland. This means that Columbus will lose not one but two physicians who have been active in the community service projects; MARGARET PEEPLES (Mrs. William J.) is a pediatrician and has been in charge of the health department school program.

SAMUEL W. PERRY, H. BAGLEY BENSON and RICHARD E. BOGER, Atlanta, announce the removal of their offices to Suite 509, Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E.

EDNA SMITH PORCH, Atlanta, addressed the January meeting of the Fifth District League of Nursing at the Fulton County Health Center. Dr. Porth is co-chairman of the education committee of the Peachtree Pilot Club, which is sponsoring a TB survey and educational program in Fulton and DeKalb counties during January and February. Her topic was "Some Aspects of Recent Treatments of TB."

ALBERT A. RAYLE, SR., ALBERT A. RAYLE, JR., and J. FRANK WALKER, Atlanta, announce their association in the practice of radiology with offices at 255 Doctors Building, 490 Peachtree Street, N.E., and 435 Strickler Building, 1293 Peachtree Street, N.E.

BEN S. READ, Atlanta, announces the removal of his office to Suite 316, 1293 Peachtree Street, N.E., with practice limited to gynecology.

HANS A. REICHEL, Savannah, has accepted appointment as official resident physician of Savannah Beach. He will fill the place left vacant by the recent death of William E. Barfield. Dr. Reichel and his family have moved to 27 Seventh Street, Savannah Beach, and his office will be on the first floor of his residence. He will continue his practice in Savannah at 302 E. Huntingdon Street.

H. Y. RIGHTON, Savannah, chief of staff at Warren A. Candler Hospital, was honored, for his work during the past year, on January 20th at a dinner meeting of the hospital's board of trustees. He was presented a silver platter by the board.

SAMUEL F. ROSEN, Savannah, president of the Georgia Medical Society, has announced the dates and suggested topics of our medical fora to be presented in Savannah by the society. They will be held on March 1, March 15, March 22 and March 30.

JACK G. STANDIFER, Blakely, recently was elected

illustrious potentate of Hasan Temple, Ancient Arabic Order of Nobles of the Mystic Shrine, at the annual meeting held in Albany.

V. P. SYDENSTRICKER, Augusta, has received a \$10,000 grant from the Division of Research Grants of the National Institute of Health. The grant is for the study of "Hepatic Disease in Relation to Amino-acid and Vitamin Deficiency." Dr. Sydenstricker received the grant for continuation of a long-term project aimed at throwing light on biochemical functions of the liver.

PAUL TEPLIS, Atlanta, announces the removal of his offices to Suite 728, Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E.

BEN R. THEBAUT, Atlanta, announces the removal of his offices to Suite 709, Strickler Building, 1293 Peachtree Street, N.E., with practice limited to surgery.

ED M. WALKER, Pelham, has given up his practice in Pelham, where he was associated with J. C. BRIM in the Pelham Clinic, to move to South Bend, Indiana.

ROY WALLER, JR., Columbus, has been appointed by the city and county commissions to fill a vacancy on the Muscogee County Health Board, and ROY GIBSON was reappointed to the board at the same time.

C. W. WHITWORTH, Gainesville, has been named chief of the Hall County medical staff, succeeding JOHN K. BURNS. HOMER LANCASTER was elected vice-chief, and BEN GILBERT is the new secretary. RALEIGH GARNER, RAFE BANKS, JR., and WILLIAM HARDMAN were appointed to the executive committee.

CHARLES P. YARN, JR., Atlanta, announces the removal of his office to Suite 526, Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree Street, N.E., with practice limited to plastic, reconstructive and maxillo-facial surgery.

News from the Southern Medical Association

Mr. C. P. Loran has been elected Advisor and Professional Relations Counselor of the S.M.A. His main office will remain in Birmingham.

Mr. V. O. Foster has been elected Executive Secretary-Treasurer of the S.M.A. Mr. Foster is well known for his medical affiliations both in Tennessee and in Georgia.

Dr. R. H. Kampmeier, of Nashville, Tenn., has been elected Editor of the *Journal of the Southern Medical Association*. The format of the *Journal* has been changed materially.

Mr. C. P. Loran, Dr.'s Thomas Spies and R. L. Sanders, of the Southern, received high honors recently at a meeting in Cuba of the Colegio Medico Nacional de Cuba, which recognizes a most harmonious activity and good relationship between Southern doctors and their distinguished Cuban confreres.

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1955 by the Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; 1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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COVER

Cover illustration is by Miss Kathleen Mackay and Ted F. Leigh, M.D.

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(This list can be no more correct than your county secretary makes it. Ed.)

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FINAL WARNING!

DEADLINE: APRIL 1
FOR 1955 DUES

From Association Constitution and By-Laws — Chapter 8, Sec. 1 & Sec. 3

. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is properly remitted.

. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members.

. For the purpose of medical defense a member shall be deemed in arrears from and during the period extending from April 1st of the current year until his dues and assessments shall have been received at the office of the Association having been remitted by the secretary of the component county society of which he is a member.

Have Your County Society Secretary Remit
Your Dues Immediately If You Are Delinquent

Invitation

To All Association Members

MAG ANNUAL SESSION FOR 1955

- **DATES:** MAY 1-4: All Program under one roof at the swank Bon Air Hotel, Augusta, Georgia
- **SCIENTIFIC PROGRAM:** Arranged for both the "Specialist" and the "General Practitioner".
- **CLINICAL PAPERS:** Chosen to present the latest developments in the field of medicine.

WHAT'S NEW IN MEDICINE . . .

- in **Pediatrics:** Edith Potter, M.D., Chicago, Ill.
- in **Obstetrics:** Bayard Carter, M.D., Durham, N. C.
- in **Medicine:** Gould Andrews, M.D., Oak Ridge, Tenn.
- in **Radiology:** Richard H. Chamberlain, M.D., Philadelphia, Pa.
- in **Anesthesiology:** Stuart C. Cullen, M.D., Iowa City, Iowa
- in **Urology:** Elmer Hess, M.D., Erie, Pa.
- in **Surgery:** Champ Lyons, M.D., Birmingham, Ala.
- in **Industrial Surgery:** Earl D. McBride, Oklahoma City, Okla.
- in **Thoracic Diseases:** Edith Lincoln, New York, N. Y.
- in **Anesthesiology:** David A. Davis, Chapel Hill, N. C.
- in **Pathology:** Russell S. Fisher, Baltimore, Md.

- Attend Your Annual Session -



physician's bookshelf

REVIEWS

Campbell, Meredith, M.S., M.D., F.A.C.S., *Urology, Volumes I, II and III*, W. B. Saunders Company, Philadelphia and London, 1954, 2,356 pages, 1,148 figures, \$60.00 per set.

The three volumes of Dr. Meredith Campbell's *Urology* are composed of 2,356 pages of relevant material. The work is catalogued and indexed in such a way that the reader can readily find a reference.

In compiling the material, Dr. Campbell solicited the service of 51 physicians, most of whom are outstanding in the field of urology, to write one or more chapters. Each collaborator, in addition to expressing his views on the assigned subject, included a comprehensive review of the literature pertaining to his subject.

The author has endeavored to bring urologic literature up to date. The associated fundamental sciences such as Physiology, Biochemistry, Neurology and Endocrinology are included. The work is current and liberally illustrated. It is recommended for medical libraries and to those primarily interested in urology.

Rudolph Bell, M.D.

Gillilan, L. A., Ph.D., M.D., *Clinical Aspects of the Autonomic Nervous System*, Little, Brown and Company, Boston, 1954, 316 pages, 42 illustrations, \$6.50.

This monograph on the autonomic nervous system presents the anatomy and physiology of this system with emphasis on its role in clinical medicine. Part I deals mainly with anatomy and physiology, with successive chapters on the cerebral centers, the peripheral system, central pathways, autonomic innervation of the head and visceral sensation. Referred pain is discussed, as is the question of body-types (sympathotonic, vagotonic and damphotonic) and their possible significance in clinical medicine and surgery. The role of the autonomic nervous system in psychosomatic disorders is discussed throughout the book. The fact that many variations in the anatomy of the peripheral sympathetic system occur is stressed. Part II deals with the specific innervation of organ systems with discussions of clinical significance. There are chapters dealing with the cardiovascular system, the respiratory tract, glands, the digestive system, urogenital system and visceral pain (abdominal and pelvic). The anatomic diagrams are simple and clear, and while no claim is made for new facts, one may find here a summary of present knowledge which should be useful to any clinician.

William A. Smith, M.D.

Ryan, Robert E., *Headache, Diagnosis and Treatment*, The C. V. Mosby Co., St. Louis, 1954, 338 pages, \$6.50.

This book on "Headache Diagnosis and Treatment" is indeed a book about which we physicians can become enthusiastic. It fills a much needed field of study. The material is that complete and concise that the reader can easily follow, digest and put to good use the information gleaned. Each type of headache is properly visualized, the differential diagnosis clearly shown, treatments both symptomatic and prophylactic outlined and case histories related. It is remarkable how much subject matter has been compiled and correlated in only 327 pages. The author, Dr. Robert E. Ryan, is to be congratulated.

James M. Hicks, M.D.

Problems of Infancy and Childhood—Transactions of the Seventh Conference March 23 and 24, 1953, New York, N. Y. Edited by Milton J. E. Senn, M.D., Sterling Professor of Pediatrics and Psychiatry, Yale University School of Medicine, New Haven, Conn. Sponsored by the Josiah Macy, Jr. Foundation, New York, N. Y. 196 pp.

The medical director of these conferences states in the foreword to this volume that the informal nature and tempo of the discussions are preserved in the published transactions as far as possible in order to share with a wider group of investigators and students the essential quality of these conferences and to give others an insight into the functions of the scientific mind. This tenet is admirably adhered to; however, it is almost conceivable that had there been more editing and less preserving then this semantic and academic conference might have been of some value to a practitioner caring for children. In spite of the valiant efforts of the participating pediatricians to maintain the conversation at an understandable level, the psychiatrists, who dominate the conference, are soon involved in a very complex and theoretical 132 disappointing pages in which the problems for discussion are soon lost. If any of this was of practical value it was so well camouflaged that the reviewer did not recognize it. The appendix consists of a round-table on rooming-in arrangements for obstetrical-pediatric departments as practiced in a few hospitals in this country as well as abroad; it seems such arrangements are proving beneficial. A cumulative index of these and the previous transactions concludes this final volume.

Albert A. Rosenberg, M.D.

Green, Morris, M.D., and Richmond, Julius B., M.D., *Pediatric Diagnosis*, W. B. Saunders Company, Philadelphia, 1954, 436 pp., \$10.00.

This new book presents a broad approach to physical and differential diagnosis as applied to the infant, child and adolescent. It should prove stimu-

lating and of practical value to the student and practitioner interested in the care of children.

The book has been divided into four general sections. The first pertains to the taking of the pediatric history. Not only is the general technique of obtaining a history from the parents and child discussed, but also the opportunity it affords the physician in evaluating family relations and the psychological background of the child.

The second section deals with the physical examination. It is emphasized that the sympathetic and proper approach of the physician to the child may well be the difference between a satisfactory or an unsatisfactory examination. It is pointed out that a properly conducted physical examination and accurate history may be of potential psychotherapeutic value. Incorporated in this chapter is a very comprehensive list of diseases under the headings of various abnormal physical findings. The disease entities are not only listed but many are briefly discussed.

The third section is the most practical. This deals with symptom diagnosis. As the authors state, they have not included every symptom encountered. They have, however, in a limited space, compiled a very comprehensive list. A brief discussion is given of the abnormal physiology producing the symptoms, as well as a list of specific diseases which may cause them.

The final section has to do with health supervision and focuses attention on the growing importance of this field of medicine. Its implication is that the physician's responsibility is the total care of the child in its broadest aspect.

The format of the book is excellent and it is well-indexed. References have been incorporated in the body of the text rather than at the end of each chapter. This innovation should encourage reference to the original sources, and might well be used by other authors.

James P. Hanner, M.D.

John D. Campbell, M.D., Manic Depressive Disease, Clinical and Psychiatric Significance, J. B. Lippincott, 1953.

This book is reviewed, not from the psychiatric therapeutic point of view, but from the point of view of a pediatrician and as a worker in the field of preventive medicine, concerned with the welfare of mothers and children. If properly utilized, it seems to have much to offer those of us interested in and responsible for the mental health of the future generation.

The schizophrenic sooner or later stands out clearly as being in obvious need of therapy. However, too little attention has been paid to the mild manic-depressive in terms of early recognition and of prevention of progression.

The case histories, particularly those of the children, are illustrative and thought provoking. Those physicians in pediatrics and in general practice with children have a great opportunity and indeed an obligation to recognize that there apparently exists an autonomic predisposition to manic-depressive disease on a constitutional basis. When susceptible persons are subjected to aggravating and precipitating factors in sufficient degree, disability results. The typical host-parasite relationships involving susceptibility, size of dosage and virulence is increased. This could be constructively used by early recognition of problems or potential problems, followed by assistance to parents in understanding and acceptance. Developing the child's strength, and increasing his immunity to the negative would-be destructive factors, is the next step. As the child grows, it would amount to helping both parents and children to learn compensations and balance, in order to avert later mild maladjustment or more serious trouble.

"Know Thyself" is important to maturity. The physician is often in a position to implement this knowledge for both parents and children at a much earlier time, and often in a much easier way, than is any other one person. The importance of knowledge of the entire family emotional pattern and background becomes even more important in this day of office practice and specialization by age group. The large number of relatively transient families also tends to increase the need for tactful query to determine family reaction patterns. Undoubtedly, these patterns were usually known and helpful to the family physician of the past. However, the alert physician of today, be he specialist or not need not necessarily be at loss.

The chapter on referral of a patient to a psychiatrist should be of practical interest and value. Certainly the emphasis on the need for more psychiatric beds in general hospitals cannot be disputed.

The discussion of continued research as a basis of scientific prophylaxis of mental disease, recognizing the roles and responsibilities of many agencies including that of the health department, was welcome.

The idea that medical students could well be allowed the experience of the effects of certain drugs disturbing to the autonomic system, to increase their understanding, will take many back to medical school days. It merits attention.

The quotation "For that which is but a fleabite to one causeth insufferable torment to another," expresses an optimistic and sympathetic attitude toward both patients and their physicians. It could well be more universally utilized in our relations to ourselves, as well as to those with whom we live and work.

Helen Bellhouse, M.D.



Some Common Cardiac Arrhythmias

CHARLES E. BROWN, M.D., Atlanta, Ga.

THE PHYSICIAN CONFRONTED with a cardiac arrhythmia must decide how to treat it, and his decision must be based on clear concepts as to the etiology and significance of the pulse disorder in question.

The purpose of this article is to discuss two of the most common arrhythmias confronting physicians: premature contractions and auricular fibrillation.

Premature Contractions

Premature contractions are not always innocent and functional, although they are of common occurrence in healthy hearts. Auricular premature contractions may signify impending auricular fibrillation; hence it is important to rule out *mitral stenosis*, *hypertensive* or *arteriosclerotic heart disease*, or *thyrotoxicosis* before dismissing the patient with reassurance.

In digitalized patients, premature contractions of auricular or ventricular origin may be due to overdosage of digitalis, especially if the premature beats produce coupling.

Premature ventricular contractions in a patient with acute coronary occlusion are cause for alarm and prompt appropriate action, for they may precede serious ventricular tachycardia or fatal ventricular fibrillation. Such hearts need oxygen, and they also need one of the drugs capable of depressing ventricular irritability, prolonging the myocardial refractory state and slowing conductivity. (Consult standard works for dosage schedules and precautions.) In addition, relief of pain by morphine probably diminishes reflex coronary artery constriction with resulting improvement in coronary blood flow. Digitalis may be harmful because excessive doses increase ventricular irritability. Hence if digitalis must be used to combat failure in this situation, it is important to avoid over-digitalization and to recall that full digitalization may be produced by one-third less than the usual digitalizing doses.

Auricular Fibrillation

Auricular fibrillation may occur in a normal heart, but it is more likely that *mitral stenosis*, *thyrotoxicosis*, *arteriosclerotic*, *hypertensive heart disease* or *congestive failure* is present. Management requires controlling tachycardia by slowing to a more favorable rate, or converting to normal sinus rhythm if possible, while also treating the underlying disease. If failure is present, the rate may usually be slowed by the proper use of digitalis; appropriate rest, diuresis and sodium restriction are sometimes necessary also. Auricular fibrillation with tachycardia which is resistant to digitalis suggests fever, anemia, thyrotoxicosis or a toxic increase in myocardial irritability.

The physician who attempts conversion of auricular fibrillation to normal sinus rhythm must weigh the dangers of embolism on conversion against the dangers of allowing fibrillation to persist. There is certainly danger of embolism as long as fibrillation continues, and some authorities consider that the danger that embolism will be produced by conversion has been too much feared. Calculated risk is involved in both courses. If it is decided to attempt conversion, a plan which contains the most precautions is hospitalization with effective anticoagulant therapy for three weeks; this minimizes the likelihood that a fresh thrombus is present and allows time for some organization of old thrombi. Quinidine may then be given according to one of the several recommended dosage schedules, repeating the course several times if necessary. Digitalization before quinidinization is desirable to lessen tachycardia in the transition.

Rationale of Drug Therapy

In selecting drugs for the treatment of the above arrhythmias, one should think in terms of the properties of cardiac muscle, the intrinsic conducting

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.

mechanism and the actions of drugs with respect to these properties.

In general, procaine amide acts similarly to quinidine, and, while quinidine is usually the drug of choice when one of these is indicated, procaine amide is fortunately available as an excellent alternative. Quinidine and procaine amide are *relatively* contraindicated when delayed conduction (intra-ventricular or atrioventricular) is present; this situation obtains in bundle branch block and intraventricular conduction defect. These myocardial depressants are *absolutely* contraindicated in complete atrioventricular block where the preservation of ventricular impulse formation is essential.

Digitalis in therapeutic doses increases the force and efficiency of cardiac muscle contraction, slows

atrioventricular conduction and increases the myocardial refractory state, both in auricle and ventricle. In larger doses digitalis increases myocardial irritability and shortens the refractory phase. When death results from digitalis toxicity, the mechanism of death is usually ventricular fibrillation. This emphasizes the caution against over-digitalization in myocardial infarction.

The treatment of these common arrhythmias is a subject not possible to reduce to capsule form, hence no attempt has been made to offer the details of treatment. As in other phases of medicine, there is no substitute for sound clinical judgment and the application of knowledge available from the pre-clinical sciences. Rules-of-thumb should not be relied upon.

March 30th--Doctors' Day

SINCE 1933 DOCTORS in the United States have been honored on March 30th as a tribute to the unsung service, the long hours and devoted dedication to alleviating the suffering and disease of mankind.

Particularly in this day and age is this tribute to doctors, sponsored by the medical auxiliary, of value in calling to the attention of the lay public the services, often unremunerative, that are afforded by their doctors.

Mrs. G. B. Almond, of Winder, Georgia, first presented to the Barrow County Medical Auxiliary, with Mrs. E. R. Harris presiding, a resolution which was adopted in March, 1933. It read: "Whereas the Auxiliary to the Barrow County Medical Society wishes to pay lasting tribute to her Doctors; therefore, be it resolved by the Auxiliary to the Barrow County Medical Society that March 30th, the day that famous Georgian, Dr. Crawford W. Long, first used ether anesthesia in surgery, be adopted as DOCTORS' DAY, the object to be the well being and honor of the profession, its observance demanding some act of kindness, gift or tribute in remembrance of the Doctors."

In observance of the day, the Auxiliary mailed cards to the doctors and their wives. Flowers were placed on the graves of deceased doctors including that of Dr. Crawford W. Long. The first DOCTORS' DAY concluded with an elegant dinner at the spacious home of Dr. and Mrs. William Randolph with appropriate toasts, tributes and responses,

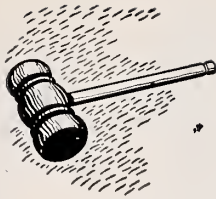
and the hope was expressed that hereafter DOCTORS' DAY would continue to be observed on March 30th of each year. In 1934 the idea was introduced to the Woman's Auxiliary to the American Medical Association and in 1935 to the Woman's Auxiliary to the Southern Medical Association. Today it is observed by almost every state auxiliary in the nation.

Newspaper editorials, radio and TV tributes, donations to the American Medical Education Foundation, wreaths on the graves of deceased physicians, scholarships for nurses and medical students, proclamations by mayors and governors and sermons from the pulpit all contribute to setting this day aside annually to honor our men of medicine.

The Woman's Auxiliary to the Medical Association of Georgia is particularly proud to have among its members the originators of DOCTORS' DAY, proud of the red carnation as it signifies an honored physician and proud of its medical family attendance at church on the Sunday prior to March 30th each year.

As each county auxiliary executes some personal tribute to the members of its medical society in the form of entertainment and relaxation, remember, Doctor, it is your day. March 30th is dedicated to you as you rededicate your professional life to service.

*Mrs. E. M. Dunstan
Doctors' Day Chairman
Auxiliary to the Medical
Association of Georgia*



president's page

The 105th Annual Session of the Medical Association of Georgia, which will be held at the Bon Air Hotel in Augusta May 1, 2, 3 and 4, 1955, promises to be the best meeting this Association has ever held.

The Medical Association of Georgia has made great strides forward and is now recognized as one of the leading state medical associations. This is because of the increased interest of each individual member in his own county society as well as in the state association. This interest must be continued, and a good way to show our interest is to attend the meetings. Any organization needs the active support of its constituents if it is to function for the best interests of them and the purposes for which we are organized. I hope each member will attend all or as much of this session as he possibly can.

The Bon Air Hotel is ideal for the meeting as it affords ample space for the scientific session, scientific exhibits, commercial exhibits and adequate facilities for social functions. Golf is Augusta's main sporting recreation, and the Bon Air certainly has this to offer.

The Committees on Arrangements, Scientific Programs and Social Functions have done a wonderful job in planning the meeting, and it is an assured fact that no one will be disappointed. The Woman's Auxiliary has seen to it that all finishing touches have been added, therefore it is highly desirable that each member bring his wife.

This meeting has been carefully planned for the general practitioner as well as the specialist, and some of the most outstanding physicians and surgeons of this country will participate in the scientific programs. Georgia's own medical talent will be noticeably present. We are indeed most fortunate in being able to secure Dr. Elmer Hess as a participant in the scientific program. Interest in the Medical Association of Georgia on a national level will be manifested by the presence of Dr. George Lull, Secretary-General Manager of the American Medical Association.

Many important matters, vital to the medical profession and the public as well, will be brought before the House of Delegates for serious consideration and action.

We of Augusta invite you, and I, as President of the Medical Association of Georgia, urge you to attend this meeting.



HUGH L. HAMILTON
MAYOR

THOS. D. BECKUM
EXECUTIVE SECRETARY

CITY OF AUGUSTA

OFFICE OF THE MAYOR

AUGUSTA, GEORGIA

February 15, 1955

TO THE DOCTORS OF GEORGIA:

As Mayor of the City of Augusta, I wish to bring you official and cordial greetings of welcome. We are delighted to have you with us and hope that your stay in our city will be pleasant and enjoyable.

Augusta is known as "The Garden City of the South", and I am sure that you would be interested in seeing some of the lovely gardens in our vicinity. These gardens are open to the public each year and have been visited by people from far and near, and have received much recognition throughout the country.

Augusta is also the home of the famous Augusta National Golf Course where the Masters Tournament is held annually. This event has attracted many thousands of people from all over the world, and no doubt some of you have attended this event in the past.

The "Little White House", home of President and Mrs. Eisenhower is also located in our city, and is built on the grounds of the Augusta National Golf Course, where the President and his family come to relax, and where the President enjoys some golf.

Also located in our City is a fine Medical Center, consisting of the University of Georgia School of Medicine; the University Hospital; St. Joseph's Hospital; and the new Eugene Talmadge Memorial State Hospital.

There are many points of historic interest in and about the city that will attract our visitors, and I sincerely hope that you will be able to take advantage of the opportunity of seeing these historic places while you are here. Ours is an old city, having been laid out in 1735, and naturally many, many changes have been made since that time, but some of the old landmarks are still standing.

We hope that you will enjoy your stay in our city, and that you will come again.

Cordially yours

HUGH L. HAMILTON
Mayor

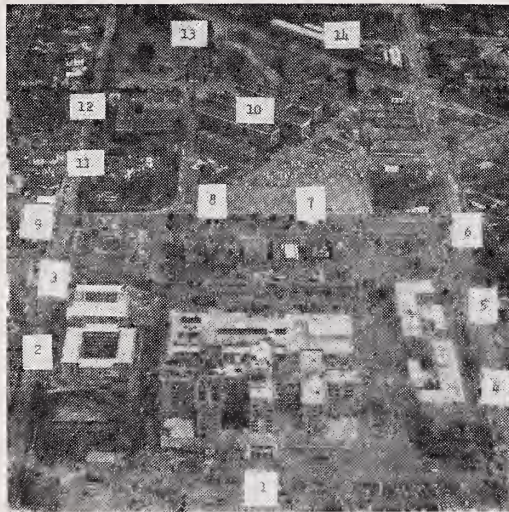
The City—Augusta



The Place—Bon Air Hotel

105th Annual Session Medical Association of Georgia Augusta, Georgia, May 1-4, 1955

1. Eugene Talmadge Memorial Hospital
2. Presidents' Quarters
3. Alcoholic Commission Bldg.
4. White Nurses' Home
5. Colored Nurses' Home
6. Administration Bldg.
7. Murphey Bldg.



8. Dugas Building
9. Richmond County Public Health Bldg.
10. University Hospital
11. Willenford Bldg.
12. Nurses' Home
13. Newton Bldg.
14. Colored Nurses' Home

Medical College of Georgia



Old Medical College Building

OFFICIAL CALL

TO THE OFFICERS AND MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA:

THE 105TH ANNUAL SESSION of the Medical Association of Georgia will be held in Augusta, Georgia, May 1-4, 1955.

The House of Delegates will convene at 5:00 p.m., Sunday, May 1, in the Crystal Room of the Bon Air Hotel.

The scientific sessions of the Association will open Sunday, May 1, with specialty section programs beginning at 2:15 p.m. Monday will be devoted primarily to general practitioners with general sessions throughout the morning and afternoon. The sections will meet Sunday, Monday and Tuesday, May 1, 2 and 3, as follows:

Sunday, 2:15 P. M.

Pediatrics and Obstetrics and Gynecology,
Joint Section

Orthopedics and Radiology, Joint Section

Monday, 2:15 P. M.

Radiology

Urology

Tuesday, 8:15 A. M.

Surgery and Anesthesiology, Joint Section
Industrial Surgery

Tuesday, 2:15 P. M.

Pathology

Anesthesiology

The president and other new officers will be installed at the General Business Session, 10:30 a.m. Wednesday, May 4.

The official Registration Desk, located in the Main Corridor of the Bon Air Hotel, will be open for registration of MAG members and guests at 1:30 p.m. Sunday and at 8:00 a.m. on Monday and Tuesday.

Peter B. Wright, President

David Henry Poer, Secretary-Treasurer

LOCAL ARRANGEMENTS COMMITTEES

RICHMOND COUNTY MEDICAL SOCIETY

General Committee

Thomas N. Goodwin, *Chairman*
Harry D. Pinson
R. C. McGahee
Joseph Mulherin

Entertainment

L. P. Holmes, *Chairman*
W. K. Philpot
Gordon Kelly
John L. Chandler, Jr.

Finance

William S. Boyd, *Chairman*
Cecil White
Louis O. J. Manganiello
W. A. Wilkes

Visual Aids

Robert B. Greenblatt, *Chairman*
Harry B. O'Rear
Mr. Jack Woods
Enon C. Hopkins

Publicity

Charles W. Hock, *Chairman*
M. H. Wylie
Philip A. Mulherin

Hotel Reservations

David R. Thomas, *Chairman*
L. Q. Hair
Alfred Battey
Perry P. Volpitta

Transportation

W. A. Fuller, *Chairman*
Theodore Everett
Jack Hudson
Nathan DeVaughn

Registration

Charles M. Mulherin, *Chairman*
Alva Faulkner
Gilbert Klemann
Goodrich Henry

Auxiliary Liaison

F. N. Harrison, *Chairman*
Alex Murphy
Carol Pryor
D. R. McRae, Jr.

Golf Tournament

Phinzy Hitchcock, *Chairman*
Emile Hummel

Hospitality

Stephen Brown, *Chairman*
W. J. Cranston
G. Lombard Kelly
Victor Roule

Luncheons and Special Dinners

Emory University
William Fuller
John T. Persall
Medical College of Georgia
Thomas E. Bailey
John M. Martin
Tu'ane University
W. A. Risteen
Edwin Rushia
American College of Surgeons
Robert C. Major
Frank Jones
Georgia Urological Society
J. R. Rinker
Seymour Friedman
Obstetrical and Gynecological Society
J. W. Thurmond
Iverson Bryans
American College of Physicians
Dewey Gray
Nathan Reeves
Georgia Academy of General Practice
M. B. Sell
Leonard Massengale
Georgia Industrial Surgeons
W. W. Battey
John Bowen
Georgia Radiological Society
Jack Levy
William Hamilton
Georgia Society of Ophthalmology and Otolaryngology
Henry Perkins
William Steed
Georgia Association of Pathologists
D. F. Mullins, Jr.
E. V. Hastings
Georgia Society of Anesthesiologists
Jack Waters
John Yarborough
Georgia Orthopedic Society
R. W. McKnight
John Faulkner
American College of Chest Physicians and
Georgia Trudeau Society
Robert Ellison
Rufus Payne
25th Anniversary, Class of 1930
W. E. Matthews

MEMBERS OF THE HOUSE OF DELEGATES

A preliminary roster of the legislative body of the Medical Association of Georgia

Delegates to the 105th Annual Session of the Medical Association of Georgia are listed below. Published in advance of the meeting, this list is subject to change.

ALTAMAHA

(Appling)

J. B. Brown, Baxley

BALDWIN

Charles B. Fulghum, Milledgeville
Wallace Gibson, Milledgeville

BARTOW

W. B. Dillard, Jr., Cartersville
Ross Whatley, Cartersville

BEN HILL-IRWIN

Herman Dismuke, Ocilla

BIBB

Henry Tift, J. B. Kay, Byron
Sam Patton, Macon
Allen Cole, Macon
W. W. Baxley, Macon
M. B. Hatcher, Macon

BLUE RIDGE

R. A. Burns, Blue Ridge

BROOKS

L. A. Smith, Quitman

BULLOCH-CANDLER-EVANS

A. J. Mooney, Statesboro

BURKE

J. M. Byne, Jr., Waynesboro

CARROLL-DOUGLAS-HARALSON

R. L. Denney, Carrollton
C. H. Allen, Bremen

GEORGIA MEDICAL SOCIETY (Chatham)

John L. Elliott, W. H. Fulmer,
Lee Howard, Jr., Ruskin King,
T. A. Peterson, David D. Robin-
son, Savannah

CHATTOOGA

H. A. Goodwin, Summerville

CHEROKEE-PICKENS

C. J. Roper, Jasper

CLARKE-MADISON-OCONEE

James A. Green, Athens
M. A. Hubert, Athens

CLAYTON-FAYETTE

T. J. Busey, Fayetteville

COBB

W. C. Mitchell, Marietta
M. M. Hagood, Marietta

COFFEE

Sage Harper, Douglas

COLQUITT

James T. Flynn, Jr., Moultrie

COWETA

G. W. Hammond, Newnan

CRISP

P. L. Williams, Sr., Cordele

DECATUR-SEMINOLE

James T. Wright, Donalsonville

DEKALB

H. Homer Allen, Decatur

DOUGHERTY

Glenn Seymour, Albany

ELBERT

D. N. Thompson, Elberton

EMANUEL

R. J. Moye, Adrian

FLOYD

Stephen D. Smith, Rome
C. J. Wyatt, Rome

FORSYTH

Marcus Mashburn, Sr., Cumming

FRANKLIN

R. E. Ridgway, Royston

FULTON

Marvin A. Mitchell, Carl C. Aven,
Alton V. Hallum, C. Purcell Rob-
erts, Lester Rumble, Jr., J. W.
Veatch, Jr., A. O. Linch, Charles
Eberhart, Chas. F. Stone, Jr., Ben
Hill Clifton, Joseph C. Massee, H.
Walker Jernigan, Haywood N.
Hill, E. A. Bancker, J. Harry
Rogers, John T. Akin, Jr., W. W.
Bryan, Elizabeth Gambrell, Irving
L. Greenberg, A. Cullen Richard-
son, Atlanta.

GLYNN

J. B. Avera, Brunswick

GORDON

Lewis Lang, Calhoun

GRADY

J. V. Rogers, Cairo

GWINNETT

D. C. Kelley, Lawrenceville

HABERSHAM

J. L. Walker, Clarksville

HALL

W. C. McCarver, Gainesville
Rafe Banks, Jr., Gainesville

HANCOCK

C. S. Jernigan, Sparta

HART

J. Hubert Milford, Hartwell

HOUSTON-PEACH

A. Smoak Marshall, Fort Valley

JACKSON-BARROW

Alex B. Russell, Winder

JASPER

J. H. Pritchett, Monticello

JEFFERSON

John J. Pilcher, Jr., Louisville

JENKINS

A. P. Mulkey, Millen

LAURENS

John A. Bell, Jr., Dublin

McDUFFIE

A. G. LeRoy, Thomson

MERIWEATHER-HARRIS

Calvin Jackson, Manchester

MITCHELL

A. A. McNeill, Jr., Camilla

MONTGOMERY

Morris Kusnitz, Alamo

MORGAN

C. H. Dickens, Madison

MUSCOGEE

A. B. Conger, R. H. Vaughan,
George Hutto, Frank Schley, Co-
lumbus

NEWTON

Clarence B. Palmer, Covington

OCMULGEE

M. F. Arnold, Hawkinsville

POLK

D. W. Schmidt, Cedartown

RABUN

George R. Boyd, Jr.

RANDOLPH-TERRELL

W. D. Martin, Dawson

RICHMOND

T. W. Goodwin, D. R. Thomas,
G. W. Wright, R. C. McGahee,
S. W. Brown, C. M. Mulherin,
R. C. Major, Augusta

SCREVEN

Gerald B. Hogsette, Sylvania

SOUTH GEORGIA

A. G. Little, Valdosta
F. G. Eldridge, Valdosta

SOUTHWEST GEORGIA

Warren C. Baxley, Blakely

SPALDING

Virgil Williams, Griffin
Alex Jones, Griffin

STEPHENS

Robert E. Shiftlet, Toccoa

SUMTER

Carl Savage, Montezuma

TATTNALL

A. G. Pinkston, Jr., Glennville

TAYLOR

R. C. Montgomery, Butler

TELFAIR

F. R. Mann, Jr., McRae

THOMAS

Rudolph Bell, Thomasville
Julian B. Neel, Thomasville

TIFT

C. S. Pittman, Jr., Tifton

TOOMBS

A. J. Yates, Soperton

TROUP

Chas. T. Cowart, LaGrange
H. H. Hammett, Jr., LaGrange

UPSON

T. A. Sappington, Thomaston

WALKER-CATOOSA-DADE

Fred H. Simonton, Chickamauga

WALTON

Lynn M. Huie, Monroe

WARE

W. L. Pomeroy, Waycross
Leo Smith, Waycross

WARREN

H. B. Cason, Warrenton

WASHINGTON

E. G. Newsome, Sandersville

WAYNE

R. A. Pumpelly, Jesup

WHITFIELD

H. L. Erwin, Dalton

WILKES

Harry L. Cheves, Union Point



H. Dawson Allen, Jr.
President-Elect



Milford B. Hatcher
Second Vice-President



Willard R. Golsan
First Vice-President



David Henry Poer
Secretary-Treasurer



Peter B. Wright, President

Officers for 1954-1955

President—Peter B. Wright, Augusta
President-Elect—H. Dawson Allen, Milledgeville
First Vice-President—Willard R. Golsan, Macon
Second Vice-President—Milford B. Hatcher, Macon
Secretary-Treasurer—David Henry Poer, Atlanta

Delegates to the A.M.A.

Terms Expire December 31, 1955

C. H. Richardson, Sr., Macon
C. L. Ayers, Toccoa, Alternate

Terms Expire December 31, 1956

Eustace A. Allen, Atlanta
William R. Dancy, Savannah, Alternate
Spencer Kirkland, Atlanta
Henry Tift, Macon, Alternate

Councilors

District		Term Expires
1—	Lee Howard, Savannah	1955 Session
2—	George R. Dillinger, Thomasville	1955 Session
3—	W. G. Elliott, Cuthbert	1955 Session
4—	J. W. Chambers, LaGrange	1955 Session
5—	Mark S. Dougherty, Jr., Atlanta	1956 Session
6—	Henry H. Tift, Macon	1956 Session
7—	D. Lloyd Wood, Dalton	1956 Session
8—	Neal F. Yeomans, Waycross	1956 Session
9—	W. Bruce Schaefer, Toccoa	1957 Session
10—	H. L. Cheves, Union Point	1957 Session

Vice-Councilors

District		Term Expires
1—	Charles T. Brown, Guyton	1955 Session
2—	Carl S. Pittman, Sr., Tifton	1955 Session
3—	Guy J. Dillard, Columbus	1955 Session
4—	Clarence B. Palmer, Covington	1955 Session
5—	J. G. McDaniel, Atlanta	1956 Session
6—	H. G. Weaver, Macon	1956 Session
7—	Ralph W. Fowler, Marietta	1956 Session
8—	James M. Hicks, Brunswick	1956 Session
9—	Charles R. Andrews, Jr., Canton	1957 Session
10—	J. Victor Roule, Augusta	1957 Session

Executive Committee

Peter B. Wright, President, Augusta
William Harbin, Past President, Rome
H. Dawson Allen, President-Elect, Milledgeville
David Henry Poer, Secretary-Treasurer, Atlanta
H. L. Cheves, Chairman of Council, Union Point
J. W. Chambers, Member of Council, LaGrange

Committee on Auditing and Appropriations

Terms Expire 1955 Session

J. W. Chambers, Chairman, LaGrange
D. Lloyd Wood, Dalton
Mark S. Dougherty, Jr., Atlanta

Honorary Advisory Board

J. W. Palmer	President, 1918-1919
C. K. Sharp	President, 1928-1929
William R. Dancy	President, 1929-1930
M. M. Head	President, 1932-1933
C. H. Richardson	President, 1933-1934
Clarence L. Ayers	President, 1934-1935
B. H. Minchew	President, 1936-1937
Grady N. Coker	President, 1938-1939
J. C. Patterson	President, 1940-1941
Allen H. Bunce	President, 1941-1942
James A. Redfearn	President, 1942-1943
W. A. Selman	President, 1943-1944
Cleveland Thompson	President, 1944-1946
Ralph H. Chaney	President, 1946-1947
Enoch Callaway	President, 1949-1950
A. M. Phillips	President, 1950-1951
W. F. Reavis	President, 1951-1952
C. F. Holton	President, 1952-1953
William Harbin	President, 1953-1954

MAG STANDING COMMITTEES, 1954-55

(One member appointed annually to serve for 3 years—terms expire at Annual Session)

Scientific Work

Charles H. Prince, Chairman, Savannah—1955
Fred H. Simonton, Chickamauga—1956
Thomas W. Goodwin, Augusta—1957
David Henry Poer, Atlanta—1957
Peter B. Wright, Augusta—1955

Legislation

Grady N. Coker, Chairman, Canton—1957
Carl C. Aven, Atlanta—1955
Joseph D. McElroy, Atlanta—1956
Mr. Roy V. Harris, Legal Advisor, Augusta—1955

Medical Education

R. Hugh Wood, Chairman, Emory University—1955
E. R. Pund, Augusta—1956
Julian Quattlebaum, Savannah—1957

Medical Defense

Marion C. Pruitt, Chairman, Atlanta—1958
David Henry Poer, Atlanta—1957
Perry Volpitta, Augusta—1956
John McPherson, Jr., Athens—1957
H. L. Cheves, Union Point—1955

Professional Conduct

Enoch Callaway, Chairman, LaGrange—1955
A. M. Phillips, Macon—1956
W. F. Reavis, Waycross—1956
C. F. Holton, Savannah—1958
William Harbin, Rome—1959

History and Vital Statistics

J. Calvin Weaver, Chairman, Atlanta—1955
H. L. Erwin, Dalton—1956
Hoke Wammock, Augusta—1957
Edgar Woody, Jr., Atlanta, Ex-Officio
Grady N. Coker, Canton, Ex-Officio

Public Health

T. A. Sappington, Chairman, Thomaston—1956
B. H. Hand, LaGrange—1957
R. F. Spanjer, Cedartown—1955
T. F. Sellers, Ex-Officio, Atlanta
Rufus Payne, Augusta—1955

Maternal and Infant Welfare

Peter Hydrick, Chairman, College Park—1956
Thos. C. McPherson, Atlanta—1957
C. M. Mulherin, Augusta—1955
Helen W. Bellhouse, Atlanta—1955
Hugh Bickerstaff, Columbus—1957
Eugene Griffin, Atlanta—1957
Howard J. Morrison, Savannah—1956
F. H. Simonton, Chickamauga—1955
George Alexander, Forsyth—1956

Woman's Auxiliary

Enoch Callaway, Chairman, LaGrange—1955
Shelley C. Davis, Atlanta—1955
Willard R. Golsan, Macon—1957
W. G. Elliott, Cuthbert—1956
W. Bruce Schaefer, Toccoa—1956

Constitution and By-Laws

J. W. Chambers, Chairman, LaGrange—1957
T. W. Goodwin, Augusta—1955
H. G. Weaver, Macon—1955
David Henry Poer, Atlanta—1957
William Harbin, Rome—1956

Awards

Hoke Wammock, Chairman, Augusta—1955
Mark S. Dougherty, Jr., Atlanta—1957
W. E. Storey, Columbus—1956

Industrial Health

Duncan Shepard, Chairman, Atlanta—1956
John G. Sharpley, Savannah—1955
Robert M. Harbin, Jr., Rome—1956
Charles L. Ridley, Jr., Macon—1957
George R. Conner, Columbus—1956
W. Bruce Schaefer, Toccoa—1955
Allen Collinsworth, Atlanta—1957
Alfred M. Battey, Augusta—1955
Subcommittee on Compensation Insurance
Allen Collinsworth, Atlanta—1955
Joseph C. Read, Atlanta—1955
Joseph Kurtz, Atlanta—1955
Duncan Shepard, Atlanta—1955

Public Relations

Chris J. McLoughlin, Chairman, Atlanta—1956
Peter L. Scardino, Savannah—1957
Thomas L. Ross, Jr., Macon—1955
J. Lamont Henry, Atlanta—1957
J. L. Chandler, Jr., Augusta—1957
Eugene Ward, Gainesville—1955
Warren M. Gilbert, Rome—1955
W. C. Cook, Columbus—1956
Geo. R. Dillinger, Thomasville—1957

Cancer

J. E. Scarborough, Chairman, Atlanta*—1955
Hoke Wammock, Augusta*—1956
David Henry Poer, Atlanta*—1957
R. C. Pendergrass, Americus*—1957
Enoch Callaway, LaGrange*—1956
W. F. Jenkins, Columbus—1955
John Funke, Atlanta—1955
John L. Barner, Athens—1956
F. D. Eldridge, Valdosta—1957
Lester Harbin, Rome—1956
Everett L. Bishop, Atlanta*—1956
Thomas Harold, Macon*—1957
Lee Howard, Savannah—1955
Neal F. Yeomans, Waycross—1956
Kirk Shepard, Thomasville—1957
Major F. Fowler, Atlanta—1955
Wadley R. Glenn, Atlanta—1956
John T. Mauldin, Atlanta—1957

*Executive Committee

Rural Health

George T. Nicholson, Chairman, Cornelia—1957
T. F. Sellers, Ex-Officio, Atlanta

Districts

1—Charles T. Brown, Guyton
2—W. P. Stoner, Sylvester
3—Maurice F. Arnold, Hawkinsville
4—T. A. Sappington, Thomaston
5—James M. Combs, Atlanta
6—W. A. Dodd, Wrightsville
7—D. M. Cornett, LaFayette
8—Clyde A. Wilson, Brunswick
9—Joe J. Arrendale, Cornelia
10—Hubert Milford, Hartwell

Insurance Board

David R. Thomas, Jr., Chairman, Augusta—1957
George Nicholson, Cornelia—1956
W. L. Pomeroy, Waycross—1956
Chas. S. Jones, Atlanta—1957

D. L. Wood, Dalton—1957
 J. Z. McDaniel, Albany—1955
 Harry Pinson, Augusta—1956
 Luther Wolff, Columbus—1955
 John Elliott, Savannah—1955

Veterans' Affairs

Hartwell Joiner, Chairman, Gainesville—1956
 A. R. Bush, Dublin—1957
 Bernard P. Wolff, Atlanta—1955
 Charles R. Andrews, Canton—1956
 Herbert Alden, Atlanta—1955
 C. C. Butler, Columbus—1955
 L. M. Freedman, Savannah—1956
 Winston Burdine, Atlanta—1957

Hospitals

H. Ansley Seaman, Chairman, Waycross—1956
 James A. Elkins, Columbus—1955
 A. J. Davis, Augusta—1956
 H. A. Goodwin, Summerville—1957
 W. D. Hazlehurst, Macon—1957
 Rafe Banks, Gainesville—1955
 R. C. Williams, Ex-Officio, Atlanta
 E. M. Lancaster, Shady Dale—1955
 J. C. Patterson, Cuthbert—1955
 Ernest Thompson, Monroe—1956
 H. E. Weems, Perry—1956
 L. C. Yeargin, Dalton—1956
 W. B. Fackler, Jr., LaGrange—1957
 R. F. Spanjer, Cedartown—1957
 H. D. Tyler, Thomaston—1957

SPECIAL COMMITTEES

(Appointed annually)

Medical Civil Preparedness

Edgar M. Dunstan, Chairman, Atlanta
 C. A. Eberhart, Atlanta Perry P. Volpito, Augusta
 T. J. Ferrell, Waycross J. S. Skobba, Atlanta
 Lee H. Battle, Jr., Rome Charles Dowman, Atlanta

American Medical Education Foundation

John L. Chandler, Chairman, Augusta
 Robt. R. McKnight, Augusta C. H. Richardson, Jr., Macon
 James S. Holder, LaGrange Sage Harper, Douglas
 Ernest F. Wahl, Thomasville J. Hubert Milford, Hartwell

Blood Banks

J. C. Thoroughman, Chairman, Atlanta
 Lee Howard, Jr., Savannah E. Val Hastings, Augusta
 Warren B. Matthews, Atlanta F. H. Thompson, Albany
 Walter Sheppard, Augusta

Abner Wellborn Calhoun Lectureship

Glenville Giddings, Chairman, Atlanta
 Charles L. Prince, Savannah Edward L. Bosworth, Rome
 Henry H. Tift, Macon

Chronic Illness

L. Minor Blackford, Chairman, Atlanta
 E. F. Wahl, Thomasville Harry T. Harper, Jr., Augusta
 W. L. Pomeroy, Waycross J. B. Neighbors, Jr., Athens
 Simone Brocato, Columbus

Crawford W. Long Memorial

Lester Rumble, Jr., Chairman, Atlanta
 Perry P. Volpito, Augusta A. B. Boyd, Athens

Mental Health

J. R. Shannon Mays, Chairman, Macon
 Paul Schroeder, Atlanta Guy V. Rice, Atlanta
 Paul Scoggins, Commerce R. D. Walters, Calhoun
 Gibson Cornwall, Fitzgerald T. G. Peacock, Milledgeville

Liaison Advisory Board to the Georgia Society for Crippled Children

J. C. Hughston, Chairman, Columbus
 Ruth M. Waring, Savannah John L. Chandler, Augusta
 James Funk, Jr., Atlanta James W. Bennett, Augusta
 Harold Muecke, Waycross

Fraternal Delegates to Adjoining States

ALABAMA: Oliver W. Jenkins, Lindale, and D. S. Reese, Carrollton
 FLORIDA: J. W. Chambers, LaGrange, and R. M. Joiner, Moultrie
 SOUTH CAROLINA: Howard J. Morrison, Savannah, and R. C. McGahee, Augusta
 TENNESSEE: William R. Dancy, Savannah, and R. N. Little, Summerville

RELATED COMMITTEES

Medical Advisory to Selective Service

William G. Hamm, Atlanta, *Chairman*
 David Henry Poer, Atlanta, *Co-chairman*
 Carter Smith, Atlanta S. A. Garrett, D.D.S., Atlanta
 T. F. Sellers, Atlanta Chas. C. Rife, D.V.M., Atlanta
 L. Minor Blackford, Atlanta Homer E. Nash, Atlanta
 Cyrus W. Strickler, Jr., Atlanta Dana Hudson, R.N., Atlanta
 A. O. Linch, Atlanta

First District Advisory Subcommittee

J. C. Metts, Savannah, *Chm.* Albert M. Deal, Statesboro
 William H. Fulmer, Savannah Cleveland Thompson, Jr., Waynesboro
 Oscar H. Lott, Savannah A. G. Pinkston, Jr., Glennville
 David B. Fillingim, Savannah J. D. McArthur, Lyons
 David Robinson, Savannah
 J. A. Mooney, Statesboro

Second District Advisory Subcommittee

Miles W. Williams, Camilla, Harry B. Baxley, Donalsonville
Chairman James R. Paulk, Moultrie
 Walter P. Rhyne, Albany Paul W. Lucas, Tifton
 J. Zeb McDaniel, Albany Howard L. Cheshire, Thomasville
 John P. Tucker, Bainbridge Jos. I. Palmer, Thomasville
 Kirk Shepard, Thomasville

Third District Advisory Subcommittee

J. H. Robinson, III, Americus, Maurice F. Arnold, Jr., Hawkinsville
Chairman Charles E. McArthur, Cordele R. B. Martin, III, Cuthbert
 Bon M. Durham, Americus Peter Graffagnino, Columbus
 R. C. Pendergrass, Americus Luther H. Wolff, Columbus
 L. C. Cheves, Montezuma Roy L. Gibson, Columbus
 John E. Smith, Fitzgerald

Fourth District Advisory Subcommittee

J. W. Chambers, LaGrange, *Chairman*
George P. Kinnard, Newnan
J. H. Arnold, Newnan
K. D. Grace, LaGrange
J. S. Holder, LaGrange
Douglas L. Head, Jr., Zebulon
H. C. King, Griffin
William R. King, Jr., Griffin
V. B. Williams, Griffin
James A. Johnson, Jr.,
Manchester

Fifth District Advisory Subcommittee

Robert W. Candler, Atlanta, *Chairman*
Joseph C. Massee, Atlanta
Edgar M. Dunstan, Atlanta
Sterling H. Jernigan, Atlanta
H. H. Allen, Decatur
Charles E. Dowman, Atlanta
Linton H. Bishop, Jr., Atlanta
Edgar Boling, Atlanta
T. E. McGeachy, Decatur
William K. Kerr, Chamblee

Sixth District Advisory Subcommittee

John A. Bell, Jr., Dublin, *Chairman*
E. Y. Walker, Milledgeville
O. C. Woods, Milledgeville
M. W. Hurt, Sandersville
J. R. S. Mays, Macon
Frank Vinson, Fort Valley
Fred J. Coleman, Dublin
J. P. Woodhall, Macon
W. K. Jordan, Macon
Henry H. Tift, Macon

Seventh District Advisory Subcommittee

John M. McGehee, Cedartown, *Chairman*
Roy Pope, Jr., Chickamauga
T. A. Cochran, Ringgold
D. L. Wood, Dalton
Charles M. Garland, Jr., Smyrna
Lester Harbin, Rome
John McCall, Rome
Wm. B. Quillian, Cartersville
Alfred O. Colquitt, Jr., Marietta
L. R. Lang, Calhoun

Eighth District Advisory Subcommittee

T. J. Ferrell, Waycross, *Chm.*
A. G. Little, Jr., Valdosta
B. G. Owens, Valdosta
S. T. Parkerson, McRae
J. B. Brown, Jr., Baxley
J. W. Yeomans, Jesup

H. L. Moore, Brunswick
Sage Harper, Douglas

Jesse L. Parrott, Hahira

Ninth District Advisory Subcommittee

Alex B. Russell, Winder, *Chm.*
O. C. Pittman, Commerce
John M. Hulsey, Jr., Gainesville
Edward W. Grove, Gainesville
Robert T. Jones, III, Canton
Chas. R. Andrews, Jr., Canton
Joe J. Arrendale, Cornelia
W. Bruce Schaefer, Toccoa
W. Ben Nalley, Helen
C. J. Roper, Jasper

Tenth District Advisory Subcommittee

M. C. Adair, Washington, *Chairman*
John B. O'Neal, III, Elberton
H. L. Cheves, Union Point
A. S. Johnson, Sr., Elberton
M. A. Hubert, Athens
H. T. Kennedy, Warrenton
Albert G. LeRoy, Thomson
Lynn M. Huie, Monroe
J. H. Nicholson, Madison

Augusta Advisory Subcommittee

C. G. Henry, Augusta, *Chairman*
John H. Sherman, Augusta
C. M. Mulherin, Augusta
W. K. Philpot, Augusta
G. L. Kelly, Augusta

Columbus Advisory Subcommittee

Luther H. Wolff, Columbus, *Chairman*
Roy Gibson, Columbus
Peter C. Graffagnino, Columbus
Polk Land, Columbus
S. A. Roddenbery, Columbus

Macon Advisory Subcommittee

Willard R. Golsan, Macon, *Chairman*
Charles N. Wasden, Macon
John I. Hall, Macon
Harold C. Atkinson, Macon
Thomas L. Ross, Jr., Macon

Savannah Advisory Subcommittee

L. B. Dunn, Savannah, *Chairman*
T. A. McGoldrick, Savannah
J. C. Metts, Savannah
W. L. Osteen, Savannah
Jacob Rubin, Savannah

STATE BOARDS

State Board of Medical Examiners

(Meets in June and October)

Charles K. Wall, Thomasville, President—1955
Albert M. Deal, Statesboro, President-Elect—1955
Grady N. Coker, Canton—1956
Fred J. Coleman, Dublin—1956
Glenville Giddings, Atlanta—1957
Q. A. Mulkey, Millen—1957
R. H. McDonald, Newnan—1958
J. W. Palmer, Ailey—1958
Alex B. Russell, Winder—1958
L. N. Willis, Bainbridge—1959

State Board of Health

(Meets in April and October)

R. Lee Rogers, Gainesville, Chairman (9th District)—1956
J. M. Byne Jr., Waynesboro, Vice Chairman (1st District)—1957
A. G. Funderburk, Moultrie (2nd District)—1957
O. C. Brannen, Columbus (3rd District)—1960
M. M. Head, Zebulon (4th District)—1955
Harold P. McDonald, Atlanta (5th District)—1960
A. M. Phillips, Macon (6th District)—1956
Fred H. Simonton, Chickamauga (7th District)—1956
C. J. Maloy, McRae (8th District)—1956
Thomas W. Goodwin, Augusta (10th District)—1955

Georgia Dental Association Representatives

J. M. Hawley, Columbus—1958
J. G. Williams, Atlanta—1958

Georgia Pharmaceutical Association Representatives

J. B. Butts, Milledgeville—1959
W. W. Webb, Leslie—1959

State Medical Education Board

(Meets in June and October)

John W. Mauldin, Alma, Chairman—1957
J. Hubert Milford, Hartwell, Vice-Chairman—1957

C. L. Howard, Pelham—1957
William Harbin, Rome—1953-55
Peter B. Wright, Augusta—1954-56

Medical Examiners

State Board of Workmen's Compensation

Albert A. Rayle, Atlanta
Jack C. Norris, Atlanta
F. Kells Boland Jr., Atlanta
Marcus Mashburn Sr., Cumming
Hugh Hailey, Atlanta

Hospital Advisory Council

(Meets in April and October)

Representatives from Georgia Hospital Association

Mr. Oscar Hilliard, Fort Oglethorpe, Chairman—1956
Mr. Arthur T. Stewart, Greensboro—1955
Mr. George E. Linney, Americus—1957

Representatives, Medical Association of Georgia

H. Dawson Allen, Milledgeville—1956
J. T. McCall, Rome—1956
J. K. Quattlebaum, Savannah—1957
Joseph C. Read, Atlanta—1957
R. F. Spanjer, Cedartown—1955

Representative from the Georgia Dental Association

Thomas Conner, Atlanta—1957

Representative, Georgia Nursing Association

Miss Dana Hudson, Atlanta—1957

Representatives, State at Large

Mr. Walter Graefe, Griffin—1957
Mr. J. J. McLanahan, Elberton—1957
Mr. Frank A. Smith, Clayton—1956
H. C. Derrick, Lafayette—1959
Mr. H. Carson Smith, Lawrenceville—1959

Ex-Officio Members

T. F. Sellers, Director, State Health Department
Mr. Eugene Cook, Attorney General
Mr. Alan Kemper, Director, State Welfare Dept.
Mr. B. E. Thrasher, State Auditor

DISTRICT OFFICERS

First District

John Mooney, Statesboro, *President*
William H. Fulmer, Savannah, *Secretary*

Second District

John F. McCoy, Moultrie, *President*
Julian Neal, Thomasville, *Secretary*

Third District

J. L. Stapleton, Columbus, *President*
T. Schley Gatewood, Americus, *Secretary*

Fourth District

J. M. Kellum, Thomaston, *President*
George Kinnard, Newnan, *Secretary*

Fifth District

Hartwell Boyd, Atlanta, *President*
Joseph H. Hilsman, Atlanta, *Secretary*

Sixth District

C. H. Richardson, Jr., Macon, *President*
Herbert M. Olnick, Macon, *Secretary*

Seventh District

R. D. Walters, Calhoun, *President*
Ralph N. Johnson, Rome, *Secretary*

Eighth District

Van Bennett, Valdosta, *President*
Sage Harper, Douglas, *Secretary*

Ninth District

Alexander B. Russell, Winder, *President*
George T. Nicholson, Cornelia, *Secretary*

Tenth District

Edgar Maxwell, Thomson, *President*
Ralph E. Wenzel, Social Circle, *Secretary*

SECTION OFFICERS

Georgia Society of Anesthesiologists

Jack Waters, Augusta, *President*
Lester Rumble, Jr., Atlanta, *Secretary*
Perry P. Volpitta, Augusta, *Program Chairman*

Georgia Chapter

American College of Chest Physicians

J. S. Cruise, Atlanta, *President*
Fred Crenshaw, Rome, *Secretary*
Levering Neely, Atlanta, *Program Chairman*

Georgia Academy of General Practice

George H. Alexander, Forsyth, *President*
Ben K. Looper, Canton, *Secretary*
Fred Simonton, Chickamauga, *Program Chairman*

Georgia Heart Association

Ellison R. Cook, III, Savannah, *President*
Goodloe Y. Erwin, Athens, *Secretary*
A. Calhoun Witham, Augusta, *Program Chairman*

Georgia Industrial Surgeons Association

Rufus Askew, Atlanta, *President and Program Chairman*
Charles Jones, Atlanta, *Secretary*

Georgia State Obstetrical and Gynecological Society

Albert Kelley, Savannah, *President*
Eugene Griffin, Atlanta, *Secretary*
Charles Mulherin, Augusta, *Program Chairman*

Georgia Society of Ophthalmology and Otolaryngology

Tom Harbin, Rome, *President*
Alton V. Hallum, Atlanta, *Secretary*
J. Victor Roule, Augusta, *Program Chairman*

Georgia Orthopedic Society

C. G. Henry, Augusta, *President*

Thomas P. Waring, Savannah, *Secretary*

R. R. McKnight, Augusta, *Program Chairman*

Georgia Association of Pathologists

Ralph Monaco, Columbus, *President*
Darrell Ayer, Atlanta, *Secretary*
W. L. Sheppard, Augusta, *Program Chairman*

Georgia Pediatrics Society

Charles Boswell, Macon, *President*
C. Dixon Fowler, Atlanta, *Secretary*
R. C. McGahee, Augusta, *Program Chairman*

Georgia Chapter

American College of Physicians

Carter Smith, Atlanta, *Governor*
C. Purcell Roberts, Atlanta, *Program Chairman*

Georgia Radiological Society

F. G. Eldridge, Valdosta, *President*
Herbert Olnick, Macon, *Secretary*
L. P. Holmes, Augusta, *Program Chairman*

Georgia Chapter

American College of Surgeons

Julian Quattlebaum, Savannah, *President*
Duncan Shepard, Atlanta, *Secretary*
George Wright, Augusta, *Program Chairman*

Georgia Trudeau Society

David R. Thomas, Augusta, *President*
Sam E. Patton, Macon, *Secretary*
Rufus Payne, Augusta, *Program Chairman*

Georgia Urological Society

J. Robert Rinker, Augusta, *President and Program Chairman*
J. Z. McDaniel, Albany, *Secretary*

VOTING RULES

1. By-Laws: Chapter V, Election of Officers:

Sec. 3. "One ballot shall be given to each voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in a locked ballot box provided by the Secretary-Treasurer and kept in the custody of the Tellers designated by the President. The key shall be kept by the Chairman of the Tellers.

Sec. 4. "Voting shall take place during the hours of the Scientific Program up to 10:30 a.m. of the last day of the annual session."

2. The names of qualified voters will be given to the person or persons in charge of the ballot box by the secretaries of the component county societies. If your name is not listed, see your county society secretary—he, *and he alone*, can make corrections.

3. The Tellers Committee will hear appeals from rules promptly each day of the Session. Appeals from committee rules may be made directly to members in general session.

4. No employee of the Association shall have any connection whatsoever with the ballot box or the voting, except to supply the Tellers Committee with essential information.

Credentials Committee

(Tentative—To Be Confirmed)

Eustace Allen, Atlanta, *Chairman*
Willard R. Golsan, Macon R. C. McGahee, Augusta

Alternates

R. C. Major, Augusta Milford B. Hatcher, Macon

Tellers Committee

(Tentative—To Be Confirmed)

Ralph H. Chaney, Augusta, *Chairman*
William R. Dancy, Savannah Marvin M. Head, Zebulon

Alternates

B. H. Minchew, Waycross Grady N. Coker, Canton

REFERENCE COMMITTEES

(Tentative—To Be Confirmed)

Reference Committee No. 1

Ruskin King, Savannah, *Chairman*
George M. Hutto, Columbus, *Vice-Chairman*
William Harbin, Rome M. A. Hubert, Athens
R. L. Denney, Carrollton A. J. Mooney, Statesboro
W. B. Dillard, Cartersville Samuel E. Patton, Macon
Sage Harper, Douglas C. J. Roper, Jasper

Reference Committee No. 2

Henry H. Tift, Macon, *Chairman*
Alton V. Hallum, Atlanta, *Vice-Chairman*
H. L. Cheves, Union Point G. W. Hammond, Newnan
C. F. Holton, Savannah W. C. Mitchell, Marietta
J. B. Avera, Brunswick Charles Eberhart, Atlanta
James T. Flynn, Jr., Moultrie D. N. Thompson, Elberton

Reference Committee No. 3

J. M. Byne, Jr., Waynesboro, *Chairman*
T. A. Sappington, Thomaston, *Vice-Chairman*
W. F. Reavis, Waycross Lewis Lang, Calhoun
M. F. Arnold, Hawkinsville W. C. McCarver, Gainesville
A. B. Conger, Columbus C. M. Mulherin, Augusta
W. H. Fulmer, Savannah I. L. Greenberg, Atlanta

Reference Committee No. 4

Marcus Mashburn, Sr., Cumming, *Chairman*
James A. Green, Athens, *Vice-Chairman*

C. Thompson, Sr., Waynesboro C. S. Pittman, Jr., Tifton
John T. Akin, Atlanta Alex B. Russell, Winder
Rudolph Bell, Thomasville Robert E. Shiflet, Toccoa
S. W. Brown, Augusta Virgil B. Williams, Griffin

Reference Committee No. 5

W. L. Pomeroy, Waycross, *Chairman*
Frank Schley, Columbus, *Vice-Chairman*
A. M. Phillips, Macon F. G. Eldridge, Valdosta
W. W. Bryan, Atlanta Lynn M. Huie, Monroe
R. A. Burns, Blue Ridge E. G. Newsome, Sandersville
Charles T. Cowart, LaGrange Glenn Seymour, Albany

Reference Committee No. 6 (Special)

B. L. Shackleford, Atlanta, *Chairman*
Enoch Callaway, LaGrange, *Vice-Chairman*
Fred Simonton, Chickamauga George W. Wright, Augusta
J. A. Green, Athens J. W. Chambers, LaGrange,
ex officio

Alternates

C. L. Ayers, Toccoa W. D. Martin, Dawson
John A. Bell, Jr., Dublin A. A. McNeill, Jr., Camilla
H. B. Cason, Warrenton Lee Howard, Jr., Savannah
Grady N. Coker, Canton John J. Pilcher, Jr., Wrens
Leo Smith, Waycross C. B. Fulghum, Milledgeville
Gerald B. Hogsette, Sylvania D. W. Schmidt, Cedartown
A. G. LeRoy, Thomson

GEORGIA PHYSICIANS WHO HAVE PRACTICED MEDICINE FOR FIFTY YEARS

This list does not contain the names of *all* Georgia Physicians who have practiced medicine 50 years or more. This records the class of 1955 *only*.

J. B. Baird, Atlanta	W. R. McCall, LaGrange	Cosby Swanson, Atlanta
W. G. Banister, Rome	William L. Moss, Athens	John C. Verner, Commerce
J. A. Combs, Atlanta	Joel L. Porter, Rutledge	Robert F. Wheat, Bainbridge
V. L. Darby, Vidalia	B. O. Quillian, Douglas	A. J. Whelchel, Cordele
William B. Harrison, Athens	John W. Simmons, Brunswick	Y. H. Yarbrough, Milledgeville
F. M. Martin, Shellman		

SCIENTIFIC EXHIBITS

1. *A Guide to Parenteral Fluid Therapy*, Thomas Findley and Pierce G. Blich, Georgia Heart Association Laboratory for Cardiovascular Research and the Department of Medicine, Medical College of Georgia, Augusta.
2. *Community Blood Banks and the Clearing House System*, Darrell Ayer, Sec.-Treas., Georgia Association of Pathologists, Georgia Society of Medical Technologists, Atlanta.
3. *Fact Finding in Georgia*, Maternal and Infant Welfare Committee of the Medical Association of Georgia, Georgia Department of Public Health, Maternal and Child Health Division, Atlanta.
4. *Photographic and Transparent Sheet Reconstruction of Early Human Embryo*, Chester H. Heuser, Ph.D., Professor of Microscopic Anatomy, Medical College of Georgia, Augusta.
5. *Reconstruction of Hyperplastic Endometrial Glands*, Richard Torpin, Professor of Obstetrics and Gynecology, Department of Obstetrics and Gynecology, Medical College of Georgia, Augusta.
6. *The Ruptured Disc—Conservative, Operative and After Care*, William R. Chambers, Atlanta.
7. *The Treatment of Skin Tumors*, Robert C. Pendergrass, Americus Tumor Clinic, Americus.
8. *Your Hospital*, Alex P. Jones, Griffin-Spalding County Hospital Authority and Staff, Griffin.
9. *The Anatomy of Bronchoscopy*, William W. Faust Durden; William D. Logan and William W. Hopkins, Atlanta.
10. *Strabismus in Children*, Morgan B. Raiford and Gregory E. Flynn, Atlanta.
11. *Interesting ORL Cases*, Murdock Euen, George Roach, Robert H. Brown and Truett V. Bennett, Atlanta.

IN MEMORIAM

WILLIAM E. BARFIELD, Savannah, November 22, 1954
WILLIAM R. BARNETT, Calhoun, January 15, 1955
LEON E. BRAWNER, St. Simons Island, December 4, 1954
BENJAMIN L. BRIDGES, Thomaston, March 7, 1954
JOHN REID BRODERICK, Savannah, November 7, 1954
WILLIAM HARVEY CABANISS, Athens, April 13, 1954
EDWARD BURTON CLAXTON, Dublin, November 24, 1954
KATHERINE RICHARDS COLLINS, Quitman, August 10, 1954
JAMES HARDEN CRAWFORD, Atlanta, April 11, 1954
JOHN F. DENTON, Atlanta, January 30, 1955
ERNEST E. DOWNING, Newington, July 21, 1954
O. O. FANNING, Atlanta, February 26, 1955
J. E. FLOWERS, Doraville, February 17, 1955
WILLIAM STOKES GOLDSMITH, Atlanta, October 23, 1954
THOMAS FLETCHER HARPER, Coleman, November 27, 1954
VAUDE LEE HARRIS, Warwick, May 15, 1954
CHARLES WILLIAM HENDERSON, Columbus, August 9, 1954
SAM M. HOWELL, Cartersville, April 13, 1954
JOEL THOMAS HUTCHINS, Atlanta, July 12, 1954
LILLIAN INGRAM, Albany, November 15, 1954

J. E. JOHNSON, SR., Elberton, November 26, 1954
ROBERT WILLIAM JOHNSON, Augusta, March 16, 1954
JOHN C. KEATON, Albany, March 30, 1954
R. L. KENNEDY, Metter, April 1, 1954
ANDREW JONES KILPATRICK, Augusta, January 10, 1955
STEPHEN L. McELROY, Ocilla, March 9, 1954
CHESTER O. MIDDLEBROOKS, Athens, July 21, 1954
LEWIE HUDSON MUSE, Atlanta, Augusta 22, 1954
LESTER NEVILLE, Dillard, July 2, 1954
CHARLES H. PAINE, Atlanta, September 4, 1954
CLIFFORD AUGUSTINE PEACOCK, Columbus, December 13, 1954
CLINTON REED, Smyrna, April 26, 1954
L. G. STEWART, Ellaville, June 2, 1954
SAMUEL D. THOMAS, Carrollton, April 12, 1954
PAUL D. VELLA, Atlanta, December 28, 1954
DOUGLAS RANDOLPH VENABLE, Columbus, May 27, 1954
ROBERT JOHN WESTBROOK, Ila, December 27, 1954
ROBERT L. WHIPPLE, Cochran, December 28, 1954
JOHN D. WILEY, Milledgeville, December 24, 1954

INFORMATION

Registration

The official registration desk will be located in the Main Corridor of the Bon Air Hotel and will be open for registration of MAG members and guests at 1:30 p.m. Sunday, May 1, and at 8:00 a.m. Monday and Tuesday, May 2 and 3. Members, medical visitors and guests should register there *immediately upon arrival* in the city and obtain badges and programs.

Official Bulletin Board

All notices of an official nature will be posted on the Association Bulletin Board at the Registration Desk. Voting rules will be posted on this board at all times.

Headquarters Suite

An official headquarters suite will be maintained in the Bon Air Hotel throughout the Annual Session for special committee meetings and necessary conferences. The key may be gotten from the secretary-treasurer or the executive secretary.

House of Delegates

The House of Delegates will meet on Sunday, May 1, at 5:00 p.m. in the Crystal Room of the Bon Air Hotel and on Tuesday, May 3, at 2:30 p.m. in the Crystal Room.

Joint Memorial Service

The Joint Memorial Service of the Medical Association of Georgia and the Woman's Auxiliary will be held at 10:00 a.m. Wednesday, May 4, in the Crystal Room of the Bon Air Hotel. Tribute will be paid to those members of both organizations who have died in the past year.

President's Dinner

The President's Dinner will be held at 8:00 p.m. on Tuesday, May 3, in the Crystal and Plantation Rooms of the Bon Air Hotel. The dinner will be

preceded by a social hour given by the Richmond County Medical Society. These events are not a part of the Official Program.

Dutch Treat Social Hour and Supper

On Sunday night, May 1, there will be a dutch treat social hour and buffet supper for MAG members and their wives. The place—Augusta Country Club; time—7:30 to 9:30. This is not a part of the official program. Tickets will be sold at the Registration Desk.

Alumni Dinners

Alumni of the Medical College of Georgia, Emory University School of Medicine and Tulane University School of Medicine will have special dinner meetings on Monday, May 2, in the Bon Air Hotel. Further information about these dinners will be posted on the Official Bulletin Board at the Registration Desk.

Specialty Society Luncheons

The following specialty societies will have luncheons in the Bon Air Hotel at 12:00 noon, Sunday, May 1: Georgia State Obstetrical and Gynecological Society in the Chinese Room, J. W. Thurmond, Chairman; Georgia Orthopedic Society, Room A, R. R. McKnight, Chairman; Georgia Chapter of the American College of Physicians, Plantation Room, Nathan Reeves, Chairman; and Georgia Pediatrics Society, Crystal Room, Leonard Massengale, Chairman. On Monday, May 2, luncheons will be given by the following societies in the Bon Air Hotel: Georgia Chapter of the American Academy of General Practice, Terrace Room, M. B. Sell, Chairman; Georgia Radiological Society, Room A, Jack Levy, Chairman; and Georgia Urological Society, Chinese Room, Theodore Everett, Chairman. On Tuesday, May 2, the following societies will give luncheons at 1:00 p.m. at the Bon Air Hotel: Georgia Chapter

of the American College of Surgeons and Georgia Industrial Surgeons Association, Terrace Room, Robert C. Major and W. W. Battey, Chairmen; Georgia Chapter of the American College of Chest Physicians and Georgia Trudeau Society, Chinese Room, Robert Ellison, Chairman; Georgia Society of Anesthesiologists, Room A., A. J. Waters, Chairman; Georgia Society of Ophthalmology and Otolaryngology, Plantation Room, Henry Perkins, Chairman; and Georgia Association of Pathologists, Partridge Inn, D. F. Mullins, Jr., Chairman.

Those physicians who desire to attend any of the above will please make reservations in advance with the chairman as indicated above.

Woman's Auxiliary

The Woman's Auxiliary will have its headquarters in the Bon Air Hotel. The Registration Desk will be located in the Main Corridor of the hotel; it will be open from 11:00 a.m. to 6:00 p.m. on Sunday, May 1; from 9:00 a.m. to 5:00 p.m. on Monday, May 2, and from 9:00 a.m. to 12:00 noon on Tuesday, May 3. Auxiliary members are urged to register *immediately upon arrival* in Augusta.

Commercial Exhibits

Some 50 Commercial Exhibits are displayed in exhibit booths in the corridors at the entrance and exit of the meeting rooms. These exhibits are primarily for your education and will give up-to-date informa-

tion on the latest products and services available to the profession. It is extremely important that you visit each of these exhibits and register with these firms. Your cooperation is *requested* as these displays are designed and shown specifically for your benefit. These exhibitors actively support your Annual Session and your support of these firms is requested.

Scientific Exhibits

Scientific Exhibits are displayed in a group in the Lounge area adjacent to the entrance behind the Registration Desk. These exhibits concern recent scientific progress and are of great interest to members of the profession. Scientific Exhibit displays are prepared by physicians, and they will be at their exhibits to discuss the exhibit with you.

Tickets

Tickets will be available at the Registration Desk for the Sunday Social Hour and Buffet Supper in the Crystal Room, Bon Air Hotel, and the President's Dinner, Tuesday in the Crystal and Plantation Rooms. Wives are cordially invited to attend these events; dress is optional.

Tickets should be purchased at the time of registration. Space is limited and the Local Arrangements Committee cannot be responsible unless each member cooperates in this regard. This is your official notice—please be governed accordingly.

COMMERCIAL EXHIBITS

Booth No.	Exhibitor	Booth No.	Exhibitor
1.	Wachtel's Physician Supply Company, Savannah, Georgia.	35.	Riker Laboratories, Inc., Los Angeles 48, California
2.	Marks Surgical Supplies, Inc., Augusta, Georgia	36.	Winthrop Stearns, Inc., New York 19, New York
3.	Pet Milk Company, St. Louis, Missouri	37.	Lederle Laboratories Division American Cyanamid Company, Pearl River, New York
5.	Audio-Digest Foundation, Glendale, Calif.	38.	E. R. Squibb & Sons, New York 22, New York
10.	Surgical Supply Co., Jacksonville, Florida	39.	U. S. Vitamin Corp., New York 17, New York
11.	Desitin Chemical Company, Providence 2, Rhode Island	40.	The Wm. S. Merrell Company, Cincinnati 15, Ohio
13.	Sharp & Dohme Company, Inc., Philadelphia, Pennsylvania	41.	Eaton Laboratories, Inc., Norwich, New York
14.	The P. Lorillard Company, New York, New York	42.	S & H X-Ray Company, Atlanta, Georgia
15.	The Doho Chemical Company, New York 13, New York	45.	Wm. P. Poythress & Company, Inc., Richmond, Virginia
19.	& 20. A. S. Aloe Company, Atlanta, Georgia	46.	Sandoz Chemical Works, Inc., New York 14, New York
22.	West Pharmaceuticals, Buffalo 13, New York	47.	The Stuart Company, Chicago 1, Illinois
23.	Harrower Laboratories, Jersey City 6, New Jersey	48.	M & R Laboratories, Inc., Columbus, Ohio
24.	Ortho Pharmaceutical Corp., Raritan, New Jersey	49.	Eli Lilly & Company, Indianapolis 6, Indiana
25.	C. B. Fleet Company, Inc., Lynchburg, Virginia	50.	Brayten Pharmaceutical Company, Chattanooga 9, Tenn.
26.	J. B. Roerig & Company, Chicago 11, Illinois	51.	The Coca-Cola Company, Atlanta, Georgia
27.	Abbott Laboratories, North Chicago, Illinois	52.	Bristol-Myers Products Division, New York 20, New York
28.	Creditors Mercantile & Adjustment Agency, Atlanta, Georgia	53.	Parke, Davis & Company, Detroit 32, Michigan
29.	Hoffmann-LaRoche, Inc., Nutley 10, New Jersey	54.	Van Pelt & Brown, Inc., Richmond, Virginia
30.	Ives-Cameron Company, Philadelphia 2, Pennsylvania	55.	Ayerst, McKenna & Harrison, Ltd., New York 16, New York
31.	The Rhinopto Company, Dallas, Texas	56.	Ciba Pharmaceutical Products, Inc., Summit, New Jersey
32.	Lloyd Brothers, Inc., Cincinnati 3, Ohio	57.	Kremers-Urban Company, Milwaukee 12, Wisconsin
33.	A. H. Robins Company, Inc., Richmond, Virginia		
34.	Maltbie Laboratories Division Wallace & Tiernan, Inc., Belleville 9, New Jersey		

Additional Exhibits Booths will be listed in the Association's 105th Annual Session Program.

BE SURE TO VISIT THE EXHIBITS!

GUEST SPEAKERS

AMA Secretary and General Manager

GEORGE F. LULL, M.D., Secretary and General Manager of the American Medical Association, will address the House of Delegates meeting on Sunday, May 1, at 5:00 p. m. The title of his address is "It's Your American Medical Association."

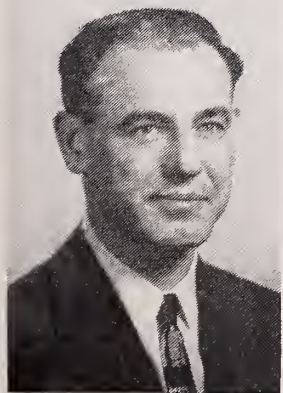
Dr. Lull is a native of Pennsylvania and received his M.D. degree from Jefferson Medical College in 1909. He holds the Doctor of Science degree from the Woman's Medical College of Philadelphia, the Master of Public Health degree from the Harvard School of Public Health and the degree of Doctor of Public Health from the University of Pennsylvania. He also has an honorary degree of LL.D. from Jefferson Medical College.



George F. Lull, M.D.

He entered the U. S. Army in 1912 and rose from the rank of First Lieutenant to that of Major General. After service in World War I he served as instructor at the Army Medical School and part time as Director of the Department of Preventive Medicine. From 1926 to January 1929 he served as Chief of the Statistical Division, Surgeon General's Office. From 1929 through 1932 he was detailed as Medical Advisor to the Governor-General of the Philippine Islands. In July 1940 he returned to duty in the office of the Surgeon General as Chief of the Military Personnel Division, and in June 1943 he was named Deputy Surgeon General of the U. S. Army, serving in that capacity until he joined the American Medical Association in January 1946, where he is now Secretary and General Manager.

Radiologist to Speak



Richard H. Chamberlain, M.D.

RICHARD H. CHAMBERLAIN, M.D., Professor of Radiology of the School of Medicine and Graduate School of Medicine, University of Pennsylvania, will be a panel member at 10:00 a. m. Monday to discuss "Radioactive Isotopes in Medicine". He will address the Radiology Section at 2:30 p. m. Monday on "Practical Application of Isotopes in Medicine".

Dr. Chamberlain received his A.B. degree from Centre College, Danville, Kentucky, and his M.D. degree from the University of Louisville School of Medicine in

1939. From 1940 through 1942, he was a Fellow in Radiology, Hospital of the University of Pennsylvania. He is a member of the American College of Radiology, the Radiological Society of North America, American Roentgen Ray Society, American Radium Society and the Philadelphia Roentgen Ray Society, of which he is president.

A summary of Dr. Chamberlain's paper "Practical Application of Isotopes in Medicine" follows:

The use of radioactive isotopes in clinical medicine has been steadily increasing during the past 10 years. Modern diagnostic techniques, such as the study of thyroid function with radioactive iodine, have become a part of regular investigative procedures in many moderate sized hospitals and some private practice offices, as well as in large hospitals and teaching centers. In the latter, a wide variety of clinical diagnostic studies are aided with isotopic methods. Well established techniques of treatment have been developed for thyrotoxicosis, severe heart disease, certain thyroid cancers, polycythemia vera, some leukemias and a considerable number of other advanced malignancies.

The use of these materials requires a good working knowledge of the principles of radioactivity, training in the safe use of radiations in human beings and experience with the operation and interpretation of the instruments which are used to detect and measure the isotopes employed.

Assistant Defense Secretary

FRANK BROWN BERRY, M.D., will present the Abner Wellborn Calhoun Memorial Lecture at 12:00 noon on Tuesday. The subject of Dr. Berry's talk is "Medical Manpower Problems in this Country and Overseas".

Dr. Berry is Assistant Secretary of Defense, Health and Medical, and Professor of Clinical Surgery at Columbia University. He is a fellow of the American College of Surgeons, diplomate and founder-member of the American Board of Surgery and the Board of Thoracic Surgery.

A summary of Dr. Berry's paper follows:

The subject of this talk is "Medical Manpower Problems in This Country and Overseas." This will be taken up first from the overall standpoint and then to point out our somewhat different obligations encountered in the United States, Alaska and overseas. The personnel needs are presented to us by the Surgeons General of the three Armed Forces. A study is then made of these requirements by this office, following which they are transmitted to the Health Resources Advisory (Rusk) Committee. This committee then agrees or disagrees. If the latter, a satisfactory compromise is worked out, and the final requirements are transmitted to the President, which he personally initials; the numbers required are then sent to Selective Service. Selective Service deals with numbers only and has no concern with the specialty needs. The requirements as presented by the three services are held within the ratio of doctors per thousand troop strength decided upon by the Rusk Committee, and are not those *desired* by the services, which are at a considerably higher figure. The present ratio was decided upon as sufficient to meet the actual needs of the services and yet prevent too great a drain upon the physicians from civilian life.



Frank Brown Berry, M.D.

The services have cooperated extremely well in meeting our present tight situation.

The basic cause for this goes back to our lower birthrate in the 1930's, and during the decade of 1940 on the other hand we had a sharply rising birthrate and at the same time an increase in longevity of our older age group, which has resulted in a temporary imbalance of our population with a considerably larger old age and much larger infant and childhood groups. These factors plus the many increasing demands for physicians in research, in preventive medicine, in industry and on the part of the public in their search for better health have resulted in a temporary shortage of physicians to fill all of our needs.

In the United States we also have the added problem of dependent care for our greatly increased Armed Forces. Alaska has shown a rapid increase in population and presents its own peculiar problems. Overseas the Armed Forces must provide care for a large number of civilians from other governmental agencies who may be working in those areas. Thus, the whole question of balance between civilian and military needs enters into our picture of a temporarily reduced supply of medical manpower.

Industrial Surgery Speaker



Earl D. McBride, M.D.

EARL D. MCBRIDE, M.D., will speak at the General Session on Monday at 9:30 a. m. and on Tuesday at 10:40 before the Industrial Surgery Section; the subjects of his talks are "Disability Evaluation for General Practitioners" and "Disability Evaluation" respectively.

Dr. McBride is Clinical Professor of Orthopedic Surgery, University of Oklahoma School of Medicine, and Chief Surgeon at the

Bone and Joint Hospital and McBride Clinic in Oklahoma City, Oklahoma. He is a diplomate of the American Board of Orthopedic Surgeons and a member of the American Orthopedic Association, the American Academy of Orthopedic Surgeons and the Association of Bone and Joint Surgeons.

A summary of Dr. McBride's paper—"Disability Evaluation"—follows:

The subject of disability evaluation is presented as an important medical subject in need of better understanding. The term disability implies depreciation from the normal physique, leaving a lessened ability to perform the useful functions of work. A method of analyzing disability is proposed which enables the doctor to achieve a comprehensive inventory, and rating, of all disabling factors.

A distinction must be made between the temporary and permanent impairment. Maximum improvement is often not attained without the advantages of rehabilitation. The permanent disability may be total or partial. The compensation laws usually provide a specific award for total permanent disability and for amputations at certain levels. The extent of partial permanent disability is determined through medical opinion. A formula is suggested for facilitating a greater degree of accuracy in arriving at a definite percentage rating. A percentage rule of severity is also suggested for measuring the percent loss of each disabling factor. Multiple disabilities are discussed.

All of the disabling factors are grouped into six units. (1.) Functional Deficiency, (2.) Anatomical Mass Damage, (3.) Clinical Manifestations, (4.) Restrictions of Job Restoration, (5.) Restrictions of Working Conditions and (6.) Reactionary and Intangible Interferences.

All the disabling factors under these headings are elicited and each factor appraised for its percent less than normal. An average of these factor ratings represents the percent loss for the unit. The formula then provides for averaging the unit losses to obtain the final rating for the disability of the case at hand.

Public Health Service Speaker

MRS. SHIRLEY H. FEREBEE, who will be on the panel discussing "Chemo Therapy of Tuberculosis" before the Thoracic Diseases Section at 10:00 a. m. Tuesday, May 3, is connected with the Tuberculosis Program, Division of Special Health Services of the Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

A research statistician, Mrs. Ferebee coordinates and analyzes the results from the United States Public Health Service large scale control studies on antimicrobial therapy of tuberculosis in cooperation with hospitals and sanatoria throughout the country.



Mrs. Shirley H. Ferebee

Anesthesiology Speaker



Stuart C. Cullen, M.D.

STUART C. CULLEN, M.D., is Professor of Surgery and Chairman of the Division of Anesthesiology at the State University of Iowa College of Medicine. He is a director of the American Board of Anesthesiology, and he is an Associate Editor of *Anesthesiology*.

Dr. Cullen was the senior instructor and organizer of an international course in anesthesiology in Copenhagen, Denmark in 1950, 1952 and 1954; this was

sponsored by the World Health Organization and the Danish Government. He has also been a member of the teams of medical scientists visiting in Austria (1947) and India (1953).

He will speak on the panel discussing "Factors Influencing Morbidity and Mortality in the Surgical Patient" before the Surgery and Anesthesiology Joint Section, 9:30 a. m. Tuesday. He will address the G. P. Day General Session at 3:00 p. m. Monday; the title of his talk is "The Scope of Anesthesia in Office Practice". He will also speak to the Anesthesiology Section at 2:30 p. m. Tuesday on "Recent Advances in the Use of Analgesics". Dr. Cullen's two papers are summarized below:

The Scope of Anesthesia in Office Practice

In view of the fact that there are numerous occasions on which it becomes either necessary or expedient to use anesthesia in the office, an attempt will be made to outline briefly the agents and technics which may be used safely and conveniently under these conditions.

These agents will include such drugs as vinethene, ethyl chloride, ether, nitrous oxide and the various local anesthetic drugs. The technics will include open drop, insufflation, semi-open and a few simple nerve blocks as well as infiltration.

Emphasized also will be the importance of proper preparation of the patient, safeguards to be used in these circumstances, hazards to be expected, and necessary equipment for the safe use of anesthesia in the office.

Recent Advances in the Use of Analgesics

A number of new analgesic drugs have been introduced. In addition, successful and dependable antagonists to the narcotic drugs have been introduced.

This discussion will present clinical and laboratory investigations of these drugs. These investigations will include the use of these drugs alone and in combination in conjunction with nitrous oxide anesthesia and in the treatment of postoperative pain.

There will be a discussion of the apparent specificity of some of these drugs for relief of particular types of pain, a discussion of the effects of the drugs upon ventilation, and a discussion of the effectiveness of the antagonists in overcoming some of the undesirable effects of the narcotic drugs.

To Talk on Chronic Pancreatitis

CHAMP LYONS, M.D., who will speak at the General Session on Monday at 2:30 p. m., is Professor of Surgery and Chairman of the Department at the Medical College of Alabama. Dr. Lyons is a native Alabamian and a graduate of the University of Alabama. He received his M.D. degree from Harvard Medical School in 1931 and served his internship and surgical residency at Massachusetts General Hospital. Dr. Lyons served with the U. S. Army in the Mediterranean Theatre during World War II and was released from active duty in 1946 and appointed Associate Professor of Surgery at Tulane; he came to the Medical College of Alabama in 1950.

Dr. Lyons' talk before the General Session is entitled "Problems in the Diagnosis and Treatment of Chronic Pancreatitis" and is summarized below:

Current interest in the problem of pancreatitis has focused attention on both diagnosis and treatment. Difficulty in diagnosis arises because of the frequency of secondary pancreatitis and the absence of any constantly reliable pattern of the chronic disease. The bile reflex theory undoubtedly explains many instances of acute and chronic pancreatitis. Increasing evidence favors an etiologically important direct obstruction of the pancreatic duct without regurgitation of bile. In either event, the end result may be pancreatic fibrosis with segmental intrapancreatic obstruction of the ducts or actual obliteration of the ducts. Recognition of the different patterns of pancreatic disorder underlies the selection of the appropriate procedure for operative relief. Methods of identifying the basic disorder and the selection of appropriate operative procedures will be presented.

Maryland Medical Examiner to Speak

RUSSELL S. FISHER, M.D., will address the Pathology Section at 2:30 on Tuesday on "Medicolegal Investigations", and he will participate in a panel discussion immediately following his talk; its topic is "Legal Medicine and Medical Examiners".

Dr. Fisher is a graduate of Georgia Tech and the Medical College of Virginia. He interned and was Assistant Resident in Medicine at Henry Ford Hospital and spent two years in the U. S. Navy Medical Corps. He spent three years as a Research Fellow in Legal Medicine at Harvard Medical School. His present positions are Chief Medical Examiner for the State of Maryland, Professor of Legal Medicine at the University of Maryland Medical School, Lecturer in Forensic Pathology,



Russell S. Fisher, M.D.

Johns Hopkins Medical School, and Lecturer in Legal Medicine, Medical College of Virginia.

Dr. Fisher's paper is summarized below:

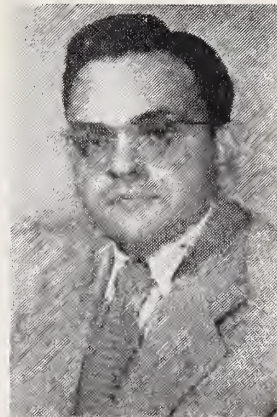
The investigation of violent, sudden or suspicious deaths in non-metropolitan areas begins with and must depend to a great extent on the general practitioner who determines that death has occurred and, in many cases, performs the gross autopsy. The importance of this assistance to the legal authorities in medico-legal investigations cannot be overestimated. Hence, the general practitioner must accept this responsibility and prepare himself with adequate knowledge of the pathology of injury and the characteristics of violent and sudden death.

The present law in Georgia seems wide enough to allow the Medical Examiner to take whatever steps are necessary to determine the cause of death beyond reasonable doubt, not only in the potential homicides, but also in the accidental deaths where compensation questions may later arise in the courts, and in the deaths from natural causes where the public interest demands that the health authorities know the cause of death if they are to prevent the spread of contagious or occupational diseases.

The necessity of careful investigation of the scene of death for trace evidence will be illustrated in this presentation. The essential features of the pathology of gunshot wounds, incised and stab wounds, blunt injuries and selected natural causes of sudden death will be demonstrated by lantern slide illustration. Attention will be given also to the role of alcoholism in violent deaths and some basic considerations in the collection of samples for toxicologic analysis. The presentation will be oriented for the general practitioner who is seeing the occasional medicolegal death as well as the pathologist who may be called upon to conduct medicolegal autopsies.

To Speak on Radioactive Isotopes

GOULD A. ANDREWS, M.D., is an internist whose chief interests are in hematology and radioisotopes. He obtained his medical training and served as instructor in internal medicine at the University of Michigan. Since 1949 he has been Chief of Clinical Services at the Medical Division of the Oak Ridge Institute of Nuclear Studies.



Gould A. Andrews, M.D.

Dr. Andrews will participate in a panel discussion on "Radioactive Isotopes in Medicine" at 10:00 a. m. Monday at the G. P. Day General Session. He will also address the Medicine and Heart Joint Section at 3:30 p. m. Sunday; the summary of his talk "Radioactive Isotopes in Medical Research" follows:

Although popular publications have often implied that the chief contribution of radioisotopes to medicine is in the therapy of cancer, these new materials at present have their widest application in research, where they make possible new techniques for the study of fundamental biologic processes.

In recent years much emphasis has been placed on the study of radiation effects and here isotopes may be used as a source of radiation to produce changes in tissue. However, in an even larger number of investigations, involving diverse fields of biology, isotopes are used as tracers; the radioactive substance serves only to provide certain techniques of detection and measurement; the interpretation of such experiments is based chiefly upon biological information rather than upon knowledge of radiation physics.

The research in the Medical Division of the Oak Ridge Institute of Nuclear Studies has emphasized efforts to use radioisotopes in the treatment of neoplasms and other diseases, but it has also included studies of radiation effects and of physiologic problems related to medicine. Measurements of the distribution of isotopically tagged compounds in experimental animals have

constituted a large share of the effort. Autoradiographic methods have proved invaluable in demonstrating the details of distribution of isotopes in tissues. Particular emphasis has been placed on correlation of the data derived from isotopes with histologic, biochemical, and clinical information.

Examples of such studies will be presented.

AAGP President To Make Address



John R. Fowler, M.D.

JOHN RICHARD FOWLER, M.D., 1955 President of the American Academy of General Practice, will address the General Session on G. P. Day at 4:00 p. m.; his subject will be "Philosophy in Office Procedure".

Dr. Fowler is a native of South Carolina and a graduate of the Medical College of Georgia, class of 1914; he now lives in Barre, Mass. He holds a bachelor of laws degree from the American Extension University. A

charter member of the A.A.G.P., he was present at the first organizational meeting in Atlantic City in 1947. He was a charter member of the Massachusetts chapter and the first president. Dr. Fowler has always been active in civic affairs; during World War II he was medical director of civilian defense for Barre.

Dr. Fowler, in his talk "Philosophy in Office Procedure", will outline one or two specific procedures and elaborate on the philosophy of public relations as it applies to any procedure.

Obstetrics and Gynecology Speaker

BAYARD CARTER, M.D., Professor of Obstetrics and Gynecology at the Duke University School of Medicine since 1931, will be one of the speakers on the panel discussing "Important Factors in Perinatal Mortality" at 8:00 a. m. Monday. This will be part of a General Session on G. P. Day. Dr. Carter will also address the Pediatrics and Obstetrics and Gynecology Joint Section at 4:30 p. m. Sunday. His topic will be Management of Obstetrical Difficulties with Relation to Fetal Outcome".

Dr. Carter received his B.A. and M.A. degrees at the Honour School of Physiology at Oxford University, England. He returned to the United States and graduated from Johns Hopkins Medical School in 1925.

A resumé of his paper follows:

Efforts will be made to show that there is a relationship between the course of labor and the type of delivery and fetal survival. Over many of these factors the medical attendant has little control; for other factors he can exercise certain precautions.



Bayard Carter, M.D.

AMA President-Elect to Speak

ELMER HESS, M.D., President-Elect of the American Medical Association, will address the General Business Session Monday at 11:40. The title of his address will be "The AMA". At 2:30 that same day, he will speak to the Urology Section on "Management of Cancer of the Bladder".

Dr. Hess was born in New Jersey and received his M.D. degree from the University of Pennsylvania in 1911; he now lives in Erie, Pennsylvania. He served with the U. S. Army in France during World War I. In 1919 he returned to civil life and took graduate courses in Europe and at Johns Hopkins University, Baltimore. Since 1920 he has specialized in Urology and is editor and publisher of the *Urolog*, a quarterly bulletin. He is chief of the urological departments at St. Vincent's Hospital and Hamot Hospital in Erie, Pennsylvania. Dr. Hess has served as president of the Erie County Medical Society, the Medical Society of the State of Pennsylvania, the Pan American Medical Association Section on Urology, the American Urological Society and of the Dr. Hess Urological Foundation. He has been a member of the AMA House of Delegates since 1946 and a member of the AMA Council on Medical Service since 1947 (chairman; 1952-54).



Elmer Hess, M.D.

Pediatrics Speaker



Edith Potter, M.D.

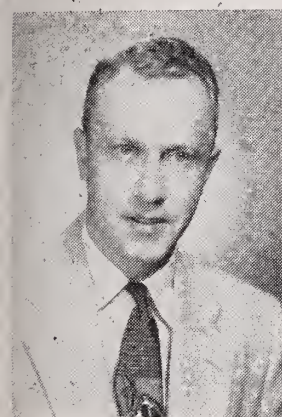
EDITH POTTER, M.D., who will address the Pediatrics and Obstetrics and Gynecology Joint Section on Sunday at 4:00 p. m., is Associate Professor of Pathology in the department of obstetrics and gynecology at the University of Chicago and Pathologist, the Chicago Lying-in Hospital. She is the recipient of an award for outstanding work from the University of Minnesota and the New York Infirmary for Women, and she has

received honorary degrees from the University of Brazil and the Women's Medical College. Dr. Potter is the author of *The Pathology of the Fetus and Newborn*.

Dr. Potter will be a member of the panel discussing "Important Factors in Perinatal Mortality" at the General Session. The time of this discussion is 8:00 a. m. Monday. Her address to the Pediatrics and OB and GYN Joint Section is entitled "Cytomegalic Inclusion Body Disease in Newborn Infants" and is presented in honor of the late W. A. Mulherin, M.D. A summary follows:

Cytomegallic inclusion body disease is a condition present at birth in which specific lesions are constantly present in the kidney and are variably distributed in other organs. Ectopic areas of erythropoiesis are widespread throughout the viscera and the accompanying anemia, erythroblastemia and icterus may be responsible for an erroneous clinical diagnosis of erythroblastosis fetalis. A clinical diagnosis can be made by finding characteristic cells in the urine. Most cases terminate fatally within the first week. The cause is presumed to be a placentally transmitted virus.

To Speak on Carbon Dioxide Poisoning



David A. Davis, M.D.

DAVID A. DAVIS, M.D., who will address the Anesthesiology Section at 3:30 p. m. Tuesday on "Carbon Dioxide Poisoning", is Professor of Surgery in Anesthesiology at the University of North Carolina School of Medicine, Chapel Hill, N. C. Dr. Davis was formerly Associate Professor of Anesthesiology at the Medical College of Georgia.

Dr. Davis will also participate in a panel discussion on "Factors Influencing Morbidity and Mortality in the Surgical Patient" before the Surgery and Anesthesiology Joint Section at 9:30 a. m. Tuesday. A summary of Dr. Davis' paper—"Carbon Dioxide Poisoning"—follows:

Ordinary breathing in the normal individual maintains the carbon dioxide level of the tissues in a remarkably narrow range.

When excessive amounts of carbon dioxide accumulate in the normal individual, severe respiratory distress occurs. In the anesthetized patient, carbon dioxide often accumulates to a degree which would cause extreme discomfort, unconsciousness or convulsions were the patient not anesthetized. Among factors causing carbon dioxide retention are anesthetizing apparatuses, interference with ventilation by respiratory obstruction, deep anesthesia and muscle relaxant drugs. During carbon dioxide excess the heart is often depressed, and during the recovery from this condition, further cardiac abnormalities are encountered frequently. Associated with hypercapnia, marked changes occur in the blood glucose, phosphorus and potassium levels. In the rapid return to normal, some of these changes are even more remarkable and often are associated with dangerous electrocardiographic changes. A further effect of carbon dioxide is a marked prolongation of the effects of muscle relaxants, particularly succinylcholine. This situation creates a vicious circle which may dangerously prolong the recovery from anesthesia.

Suggestions for the prevention and treatment of carbon dioxide poisoning will be presented.

To Speak on Tuberculosis

EDITH M. LINCOLN, M.D., of the Department of Pediatrics of the New York University-Bellevue Medical Center, New York University College of Medicine, New York City, will present two informal papers. The first will be on "Tuberculosis in Children" at the General Session, Monday at 3:30 p. m.; the second will be on "Results on Antimicrobial Therapy of Tuberculosis in Children" before the Thoracic Diseases Section, Tuesday at 9:30 a. m.

Dr. Lincoln is Professor of Clinical Pediatrics in the New York University College of Medicine and Visiting Physician, Bellevue Hospital. She is in charge of the Chest Clinic of the Children's Medical Service of Bellevue Hospital.

Make Your Reservations NOW!!

For the Annual Session, May 1-4, 1955

Write to Dr. David R. Thomas, Jr.

Chairman, MAG Hotel Reservations Committee

Bon Air Hotel

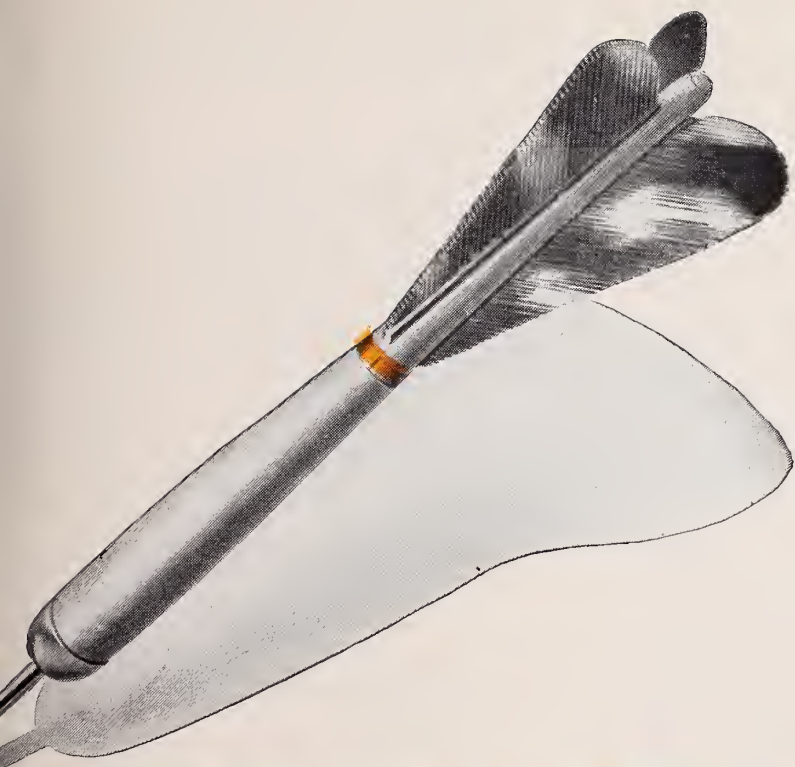
Augusta, Georgia

The Bon Air Hotel will confirm reservations until the 250 available rooms are filled.

After the Bon Air is filled, your reservation will be confirmed direct by the Partridge Inn or the Richmond Hotel.

The image features a background of concentric circles in dark grey and light grey, creating a tunnel-like effect. The text 'ACH' is prominently displayed in a bold, orange, sans-serif font with a black outline, positioned on the right side of the image.

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Typhus Fever
Sinusitis
Gonorrhea
Bacillary Dysentery
Pneumonia with or without Bacteremia
Bronchopulmonary Infection
Acute Pyelonephritis
Chronic Pyelonephritis
Mixed Bacterial Infections
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Staphylococcal Septicemia
Pneumococcal Septicemia
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THE 105th ANNUAL

SUNDAY - MAY 1

12:00	SPECIALTY SOCIETY LUNCHEONS
1:30 P. M.	GENERAL REGISTRATION <i>Main Corridor, Bon Air Hotel</i>
2:15 P. M.	SECTION MEETINGS PEDIATRICS AND OB & GYN <i>Crystal Room, Bon Air Hotel</i> MEDICINE AND HEART <i>Plantation Room, Bon Air Hotel</i> ORTHOPEDICS AND RADIOLOGY <i>Room A, Bon Air Hotel</i>
4:30 P. M.	DELEGATES REGISTRATION <i>Main Corridor, Bon Air Hotel</i>
5:00 P. M.	HOUSE OF DELEGATES MEETING <i>Crystal Room, Bon Air Hotel</i>

MONDAY - MAY 2

8:00 A. M.	REFERENCE COMMITTEES NOS. 1, 2, AND 3 <i>Place to be announced</i>
8:00 A. M.	ANESTHETIC STUDY COMMISSION <i>Room A, Bon Air Hotel</i>
8:00 A. M.	GENERAL SESSION (G. P. DAY) <i>Crystal Room, Bon Air Hotel</i>
11:30 A. M.	MAG GENERAL BUSINESS SESSION <i>Crystal Room, Bon Air Hotel</i>
12:30 P. M.	BALLOT BOX OPENS
12:30 P. M.	SPECIALTY SOCIETY LUNCHEONS
2:15 P. M.	GENERAL SESSION (G. P. DAY) <i>Crystal Room, Bon Air Hotel</i>
2:15 P. M.	SECTION MEETINGS RADIOLOGY <i>Room A, Bon Air Hotel</i> UROLOGY <i>Chinese Room, Bon Air Hotel</i>
2:30 P. M.	REFERENCE COMMITTEES NOS. 4 5 AND 6 <i>Place to be announced</i>

SESSION TIMETABLE

TUESDAY - MAY 3

8:00 A. M.	BOARD OF MEDICAL EXAMINERS <i>Chinese Room, Bon Air Hotel</i>
8:15 A. M.	SECTION MEETINGS SURGERY AND ANESTHESIOLOGY <i>Crystal Room, Bon Air Hotel</i> INDUSTRIAL SURGERY <i>Plantation Room, Bon Air Hotel</i> THORACIC DISEASES <i>Room A, Bon Air Hotel</i>
10:00 A. M.	PATHOLOGY SECTION BUSINESS MEETING <i>Chinese Room, Bon Air Hotel</i>
12:00 Noon	ABNER WELLBORN CALHOUN MEMORIAL LECTURESHIP <i>Crystal Room, Bon Air Hotel</i>
1:00 P. M.	
2:15 P. M.	SPECIALTY SOCIETY LUNCHEONS HOUSE OF DELEGATES MEETING (RECESSED) <i>Crystal Room, Bon Air Hotel</i>
2:15 P. M.	SECTION MEETINGS PATHOLOGY <i>Plantation Room, Bon Air Hotel</i> ANESTHESIOLOGY <i>Room A, Bon Air Hotel</i>

WEDNESDAY - MAY 4

10:00 A. M.	JOINT MEMORIAL SERVICE WITH WOMAN'S AUXILIARY <i>Crystal Room, Bon Air Hotel</i>
10:30 A. M.	GENERAL BUSINESS SESSION <i>Crystal Room, Bon Air Hotel</i>
11:30 A. M.	NEW COUNCIL ORGANIZATIONAL MEETING <i>Crystal Room, Bon Air Hotel</i>
11:30 A. M.	1956 ANNUAL SESSION PROGRAM CHAIRMEN'S MEETING <i>Crystal Room, Bon Air Hotel</i>

The Program

The following papers are announced to be read before the scientific sessions. The order here is not necessarily the order that will be followed in the Official Program, and minor changes may be required by conditions be-

yond the control of the MAG Committee on Scientific Work. Be sure to check your Official Program for final details.

CHARLES L. PRINCE, Savannah, Chairman

Sunday, May 1 Specialty Section Programs

12:00 SPECIALTY SOCIETY LUNCHEONS (Not a Part of Official Program)

Note: Make reservation in advance with chairman if possible.

12:00 GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY

J. W. Thurmond, Augusta, Chairman
Chinese Room, Bon Air Hotel

12:00 GEORGIA ORTHOPEDIC SOCIETY

R. R. McKnight, Augusta, Chairman
Room A, Bon Air Hotel

12:00 GEORGIA CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

Nathan Reeves, Augusta, Chairman
Plantation Room, Bon Air Hotel

12:00 GEORGIA PEDIATRICS SOCIETY

Leonard Massengale, Augusta, Chairman
Crystal Room, Bon Air Hotel

2:15 PEDIATRICS AND OB & GYN JOINT SECTION (All Physicians Invited)

Crystal Room, Bon Air Hotel

PRESIDING

Albert Kelley, Savannah, President, Georgia State Obstetrical and Gynecological Society
Charles Boswell, Macon, President, Georgia Pediatrics Society

2:30 SOME INTERESTING CONGENITAL ANOMALIES

A. J. Kravtin, Columbus

2:50 MATERNAL RUBELLA: RESULTS FOLLOWING AN EPIDEMIC

Darnell L. Brawner, Savannah

3:20 USE OF INTRAMUSCULAR TRYPSIN IN PEDIATRIC CONDITIONS

Joseph Patterson, Atlanta

3:40 DESENSITIZATION OF A PREGNANT PATIENT WITH ANTI A ANTIGEN

Eugene L. Griffin, Atlanta

DISCUSSION

G. Darrell Ayer, Jr., Atlanta

4:00 CYTOMEGALIC INCLUSION BODY DISEASE IN NEWBORN INFANTS*

Edith Potter, Chicago, Ill.

**Presented in honor of the late W. A. Mulherin, M.D. by Mr. Edward E. Rader, Baker Laboratories*

4:30 MANAGEMENT OF OBSTETRICAL DIFFICULTIES WITH RELATION TO FETAL OUTCOME

Bayard Carter, Durham, North Carolina

ELECTION OF 1956 PROGRAM CHAIRMEN

2:15 MEDICINE AND HEART JOINT SECTION (All Physicians Invited)

Plantation Room, Bon Air Hotel

PRESIDING

Purcell Roberts, Atlanta

2:30 SUCCESSFUL MANAGEMENT OF THE OBESE PATIENT

James A. Kaufmann, Atlanta

2:45 UNUSUAL PARANOID MANIFESTATIONS IN A CASE OF PSYCHOMOTOR EPILEPSY

Corbett H. Thigpen, Augusta

3:00 TACHYCARDIAS DUE TO ALLERGY

Jeff L. Richardson, Atlanta

3:15 JAUNDICE IN ACUTE CHOLECYSTITIS

J. H. Hilsman, Atlanta

3:30 RADIOACTIVE ISOTOPES IN MEDICAL RESEARCH

Gould Andrews, Oak Ridge, Tennessee

4:00 CLINICAL EXPERIENCE WITH PHENYLINDIONE, A DESERVING ANTICOAGULANT

Byron F. Harper, Jr., Atlanta

4:15 PERIODONTOCLASIA AND OSTEOPOROSIS ASSOCIATED WITH ENDOCRINE DYSFUNCTION

James K. Fancher, Atlanta

4:30 BEDSIDE DIAGNOSIS OF NONCYANOTIC CONGENITAL HEART DISEASE

Edward Holladay, C. H. Watson, Calhoun Witham, Augusta

ELECTION OF 1956 PROGRAM CHAIRMAN

- 2:15 ORTHOPEDICS AND RADIOLOGY JOINT SECTION**
(All Physicians Invited)
Room A, Bon Air Hotel
PRESIDING
Stephen W. Brown, Augusta
- 2:30 COMPLICATIONS OF ACETABULAR FRACTURE**
James F. Funk, Atlanta
- 2:50 STANDARD NOMENCLATURE FOR DESCRIPTIONS OF FRACTURES**
Robert P. Kelly and H. S. Weens, Atlanta
- 3:10 LOW BACK PAIN ASSOCIATED WITH ADOLESCENT ROUND BACK**
Tom P. Waring, Savannah
- 3:30 VITAMIN RESISTANT RICKETS**
Wood W. Lovell, Atlanta
- 3:50 DWARFISM**
J. H. Kite, Atlanta
- 4:10 RADIATION THERAPY IN BONE MALIGNANCY**
Richard Chamberlain, Philadelphia, Pa.

- 4:30 "FILM READING SESSION"**
MODERATOR
Ted F. Leigh, Atlanta
GENERAL DISCUSSION
ELECTION OF 1956 PROGRAM CHAIRMEN

- 4:30 MAG DELEGATES REGISTRATION**
Main Corridor, Bon Air Hotel

- 5:00 HOUSE OF DELEGATES MEETING**
Crystal Room, Bon Air Hotel
PRESIDING
Peter B. Wright, Augusta, President
ORDER OF BUSINESS
(See *Delegates Handbook*)
IT'S YOUR AMERICAN MEDICAL ASSOCIATION
George F. Lull, Chicago, Secretary-General Manager, AMA

Monday, May 2

G. P. Day

- 8:00 MAG REFERENCE COMMITTEES**
No. 1, No. 2, No. 3
Consult House of Delegates Blackboard for Final Meeting Time and Place

- 8:00 ANESTHETIC STUDY COMMISSION**
(All Physicians Invited)
Room A, Bon Air Hotel

- 8:00 GENERAL SESSION (G. P. DAY)**
Crystal Room, Bon Air Hotel
PRESIDING
George H. Alexander, Forsyth, President, Ga. Academy of General Practice

- 8:00 PANEL: IMPORTANT FACTORS IN PERINATAL MORTALITY**
MODERATOR
Peter Hydrick, College Park
SPEAKERS
Edith Potter, Chicago, Illinois
Bayard Carter, Durham, North Carolina
Charles M. Mulherin, Augusta
R. C. McGahee, Augusta

- 9:30 DISABILITY EVALUATION FOR GENERAL PRACTITIONERS**
Earl D. McBride, Oklahoma City, Oklahoma

- 10:00 PANEL: RADIOACTIVE ISOTOPES IN MEDICINE**
MODERATOR
Fred Simonton, Chickamauga
SPEAKERS
Gould Andrews, Oak Ridge, Tennessee
Richard Chamberlain, Philadelphia, Pa.
V. P. Sydenstricker, Augusta
Stephen W. Brown, Augusta

- 11:30 MAG GENERAL BUSINESS SESSION**
Crystal Room, Bon Air Hotel
PRESIDING
Peter B. Wright, President, Augusta

- 11:30 INVOCATION**
Rev. Robert Strong, Pastor, First Presbyterian Church, Augusta

- 11:35 ADDRESS OF WELCOME**
Hon. Hugh L. Hamilton, Mayor of Augusta
C. M. Templeton, President, Richmond County Medical Society

- 11:40 THE AMA**
Elmer Hess, Erie, Pennsylvania
PRESIDING
Willard R. Golsan, 1st Vice-President, Macon

- 12:00 PRESIDENT'S ADDRESS**
Peter B. Wright, President, Augusta
NOMINATION OF OFFICERS
Announcement of Tellers Committee
President-Elect
1st Vice President
2nd Vice President
AMA Delegate (Term beginning January 1, 1956)
AMA Alternate Delegate (Term beginning January 1, 1956)
Councilor—1st District
Councilor—2nd District
Councilor—3rd District
Councilor—4th District
Vice-Councilor—1st District
Vice-Councilor—2nd District
Vice-Councilor—3rd District
Vice-Councilor—4th District

12:30 BALLOT BOX OPENS—Location and rules posted on Official Bulletin Board — Vote Early

1:00 SPECIALTY SOCIETY LUNCHEONS (Not a Part of Official Program)

Note: Make reservation in advance with chairman if possible.

- 12:30 GEORGIA CHAPTER AMERICAN ACADEMY OF GENERAL PRACTICE
M. B. Sell, Augusta, Chairman
Terrace Room, Bon Air Hotel
- 12:30 GEORGIA RADIOLOGICAL SOCIETY
Jack Levy, Augusta, Chairman
Room A, Bon Air Hotel
- 12:30 GEORGIA UROLOGICAL SOCIETY
Theodore Everett, Augusta, Chairman
Chinese Room, Bon Air Hotel

2:00 VIEW EXHIBITS

2:30 MAG REFERENCE COMMITTEES

No. 4, No. 5, No. 6

Consult House of Delegates Blackboard for Final Time and Place

2:15 GENERAL SESSION (G. P. DAY CONTINUED)

Crystal Room, Bon Air Hotel

PRESIDING

W. G. Elliott, Cuthbert, Pres.-Elect, Ga. Academy of General Practice

- 2:30 PROBLEMS IN THE DIAGNOSIS AND TREATMENT OF CHRONIC PANCREATITIS

Champ Lyons, Birmingham, Alabama

- 3:00 THE SCOPE OF ANESTHESIA IN OFFICE PRACTICE

Stuart C. Cullen, Iowa City, Iowa

- 3:30 INDICATIONS FOR ANTIMICROBIAL THERAPY OF TUBERCULOSIS IN CHILDREN

Edith Lincoln, New York City

- 4:00 PHILOSOPHY OF OFFICE PROCEDURE

John R. Fowler, Barre, Mass., President, American Academy of General Practice

- 4:30 SPEECH AND HEARING CLINICS IN GEORGIA

Claude S. Hayes, Atlanta

- 4:45 THE IMPROVISED HOSPITAL (16 minute color film)

M. M. Van Sandt, Thomasville

2:15 RADIOLOGY SECTION

(All Physicians Invited)

Room A, Bon Air Hotel

PRESIDING

F. G. Eldridge, Valdosta

- 2:30 PRACTICAL APPLICATION OF ISOTOPES IN MEDICINE

Richard Chamberlain, Philadelphia, Pa.

- 2:50 DEVELOPING AN ISOTOPE LABORATORY

Stephen W. Brown, Augusta

- 3:10 THE EMORY UNIVERSITY COBALT TELETHERAPY UNIT

F. E. Morgan, Jr., R. L. Brown, J. H. Tolan, B. S., and H. S. Weens, Emory University

DISCUSSION

Richard Chamberlain, Philadelphia, Pa.

- 4:00 THE SCOUT FILM OF THE ABDOMEN IN ACUTE APPENDICITIS

Sava M. Roberts, Augusta

- 4:20 DIAGNOSIS AND TREATMENT OF LYMPHOBLASTOMA OF THE GASTRO INTESTINAL TRACT

Bryan Redd, Augusta

ELECTION OF OFFICERS

2:15 UROLOGY SECTION

(All Physicians Invited)

Chinese Room, Bon Air Hotel

PRESIDING

J. Robert Rinker, Augusta

- 2:30 MANAGEMENT OF CANCER OF THE BLADDER

Elmer Hess, Erie, Pennsylvania

- 3:00 PLASTIC PROCEDURES FOR THE CORRECTION OF URETEROPELVIC JUNCTURE OBSTRUCTION

Irving Victor, Savannah

- 3:20 TRANSUMBILIC PERCUTANEOUS ANTEGRADE PYELOGRAPHY AS AN ADJUNCT TO UROLOGIC DIAGNOSIS

Earl Floyd and J. Candler Guy, Atlanta

- 3:40 ABACTERIAL PYURIA

Rafe Banks, Gainesville

- 4:00 TWO STAGE REPAIR OF CONGENITAL CHORDEE AND HYDROSPADIAS

Samuel S. Ambrose, Atlanta

- 4:20 BENIGN PROSTATIC HYPERTROPHY

Rudolph Bell and Roy Stinson, Thomasville

ELECTION OF 1956 PROGRAM CHAIRMAN

Tuesday, May 3

Specialty Section Programs

8:00 BREAKFAST MEETING, STATE BOARD OF MEDICAL EXAMINERS

Chinese Room, Bon Air Hotel

PRESIDING

Grady N. Coker, Canton

SPEAKER

Mr. Everett S. Elwood, Philadelphia, Pa.

8:15 SURGERY AND ANESTHESIOLOGY JOINT SECTION

(All Physicians Invited)

Crystal Room, Bon Air Hotel

PRESIDING

George Wright, Augusta

- 8:30 AN EVALUATION OF TRANSDUODENAL SPHINCTEROTOMY IN THE TREATMENT OF CHRONIC OR RELAPSING PANCREATITIS

J. Harold Harrison, Atlanta

- 8:50 IMMEDIATE CARE OF FACIAL INJURIES

Charles P. Yarn, Atlanta

- 9:10 THE ROLE OF CONTROLLED HYPOTENSION DURING SURGICAL PROCEDURES

Edwin L. Rushia, Augusta

- 9:30 PANEL: FACTORS INFLUENCING MORBIDITY AND MORTALITY IN THE SURGICAL PATIENT

MODERATOR:

Perry P. Volpitto, Augusta

SPEAKERS

Champ Lyons, Birmingham, Alabama

J. K. Quattlebaum, Savannah

Stuart C. Cullen, Iowa City, Iowa

David A. Davis, Chapel Hill, North Carolina

ELECTION OF 1956 PROGRAM CHAIRMAN

- 11:30 ADJOURNMENT

8:15 INDUSTRIAL SURGERY SECTION

(All Physicians Invited)

Plantation Room, Bon Air Hotel

PRESIDING

Rufus Askew, Atlanta, President, Georgia

Industrial Surgeons Association

- 8:30 PANEL: FEES FOR MEDICAL SERVICES RENDERED IN INDUSTRIAL ACCIDENTS

MODERATOR

Duncan Shepard, Atlanta

SPEAKERS

Mr. Landrum Finch, Aetna Casualty & Surety Company, Atlanta

Mr. L. E. Williams, Lumbermans Mutual Casualty Company, Atlanta

C. F. Holton, Savannah

Allen Collinsworth, Atlanta

- 10:00 WRIST FRACTURES

Richard E. King, Atlanta

DISCUSSION

Darius Flinchum, Columbus

- 10:20 DIAGNOSIS AND TREATMENT OF LOW BACK PAIN FROM THE ORTHOPEDIC AND NEUROSURGICAL VIEW POINTS

William Bondurant and Robert F. Mabon, Atlanta

DISCUSSION

Joe Boland and Robert A. Sears, Atlanta

- 10:40 STANDARDIZING MEDICAL EVALUATION OF INDUSTRIAL DISABILITY

Earl D. McBride, Oklahoma City, Oklahoma

- 11:15 BUSINESS MEETING, ELECTION OF 1956 PROGRAM CHAIRMAN

- 11:30 ADJOURNMENT

8:15 THORACIC DISEASES SECTION

(All Physicians Invited)

Room A, Bon Air Hotel

PRESIDING

David R. Thomas Jr., Augusta, President, Georgia Trudeau Society

- 8:30 SPONTANEOUS PNEUMOTHORAX

C. Bedford Davis, Atlanta

DISCUSSION

J. L. Alexander, Savannah

- 8:50 MISTAKES AND SURPRISES IN THE CARE OF CHEST DISEASES

F. Levering Neely, Atlanta

DISCUSSION

Horace E. Crow, Rome

- 9:10 FATE OF ISOLATED PULMONARY NODULES

Robert H. Vaughan, Columbus

- 9:30 RESULTS OF ANTIMICROBIAL THERAPY OF TUBERCULOSIS IN CHILDREN

Edith Lincoln, New York City

- 10:00 PANEL: CHEMO THERAPY OF TUBERCULOSIS

MODERATOR

Carl C. Aven, Atlanta

SPEAKERS

Mrs. Shirley Ferebee, USPHS, Washington

Bernard Wolff, Atlanta

R. F. Corpe, Rome

R. C. Major, Augusta

ELECTION OF 1956 PROGRAM CHAIRMAN

- 11:30 ADJOURNMENT

10:00 PATHOLOGY SECTION BUSINESS MEETING

Chinese Room, Bon Air Hotel

12:00 ABNER WELLBORN CALHOUN MEMORIAL LECTURESHIP

(All Physicians Invited)

Crystal Room, Bon Air Hotel

PRESIDING

Glenville Giddings, Atlanta

- 12:00 THE MEDICAL MANPOWER SITUATION IN THIS COUNTRY AND OVERSEAS

Frank B. Berry, Assistant Secretary of Defense, Washington, D. C.

2:15 HOUSE OF DELEGATES SECOND MEETING (RECESSED)

Crystal Room, Bon Air Hotel

PRESIDING

Speaker of the House

- 2:15 ORDER OF BUSINESS (*See Delegates Handbook*)

2:15 PATHOLOGY SECTION (All Physicians Invited)

Plantation Room, Bon Air Hotel

- 2:30 MEDICAL EXAMINERS SYMPOSIUM

PRESIDING

Warren B. Matthews, Atlanta

- 2:30 MEDICOLEGAL INVESTIGATIONS

Russell S. Fisher, Baltimore, Maryland

- 3:00 PANEL: LEGAL MEDICINE AND MEDICAL EXAMINERS

MODERATOR

Warren B. Matthews, Atlanta

SPEAKERS

Russell S. Fisher, Baltimore, Maryland

Frederick Thompson, Albany

Lee Howard, Sr., Savannah

D. F. Mullins, Augusta

Herman Jones, Ph.D., Atlanta

2:15 ANESTHESIOLOGY SECTION
(All Physicians Invited)

Room A, Bon Air Hotel

PRESIDING

A. J. Waters, Augusta

2:30 RECENT ADVANCES IN THE USE OF ANALGESICS
Stuart C. Cullen, Iowa City, Iowa

3:30 CARBON DIOXIDE POISONING
David A. Davis, Chapel Hill, North Carolina

4:00 BUSINESS SESSION, ELECTION OF 1956 PROGRAM
CHAIRMAN

1:00 SPECIALTY SOCIETY LUNCHEONS (Not a Part of Official Program)

Note: Make reservation in advance with chairman if possible.

1:00 GEORGIA CHAPTER AMERICAN COLLEGE OF SURGEONS AND GEORGIA
INDUSTRIAL SURGEONS ASSOCIATION

Robert C. Major, Augusta, and W. W. Battey, Augusta, Chairmen
Terrace Room, Bon Air Hotel

1:00 GEORGIA CHAPTER AMERICAN COLLEGE OF CHEST PHYSICIANS AND
GEORGIA TRUDEAU SOCIETY

Robert Ellison, Augusta, Chairman
Chinese Room, Bon Air Hotel

1:00 GEORGIA SOCIETY OF ANESTHESIOLOGISTS

A. J. Waters, Augusta, Chairman
Room A, Bon Air Hotel

1:00 GEORGIA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Henry Perkins, Augusta, Chairman
Plantation Room, Bon Air Hotel

1:00 GEORGIA ASSOCIATION OF PATHOLOGISTS

D. F. Mullins, Jr., Augusta, Chairman
Partridge Inn

Wednesday, May 4

**10:00 JOINT MEMORIAL SERVICE WITH WOMAN'S
AUXILIARY**

(All Members and Guests)

Crystal Room, Bon Air Hotel

PRESIDING

Peter B. Wright, Augusta, President

INVOCATION

The Rev. Charles Shilling, Rector, St. Paul's
Episcopal Church, Augusta

IN MEMORIAM

MEDICAL ASSOCIATION OF GEORGIA

Enoch Callaway, LaGrange

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIA-
TION OF GEORGIA

Mrs. Stewart Flanagin, Augusta

Mrs. C. Iverson Bryans Jr., Augusta

10:30 GENERAL BUSINESS MEETING

**(All MAG and Auxiliary Members and
Guests)**

Crystal Room, Bon Air Hotel

PRESIDING

Peter B. Wright, Augusta, President

PRESENTATION OF 50 YEAR CERTIFICATES

Peter B. Wright, Augusta, President

PRESENTATION OF HARDMAN AWARD

Mr. Lamartine C. Hardman, Commerce

PRESENTATION OF CERTIFICATES OF APPRECI-
ATION

David Henry Poer, Atlanta, Sec.-Treas.

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS

Hoke Wammock, Augusta, Chairman,
Awards Committee

PRESENTATION OF PRESIDENT'S KEY

To be Announced

GOLF PRIZE AWARDS

Phinizy Hitchcock, Augusta, Chairman, Golf
Committee

SELECTION OF 1956 MEETING PLACE

ANNOUNCEMENT OF ELECTION RESULTS
Chairman, Tellers Committee

INSTALLATION OF NEW OFFICERS

ADJOURNMENT

11:30 NEW COUNCIL ORGANIZATIONAL MEETING

Crystal Room, Bon Air Hotel

11:30 MEETING OF 1956 PROGRAM CHAIRMEN

Crystal Room, Bon Air Hotel

Thirtieth Anniversary Convention,
Woman's Auxiliary to the Medical Association of Georgia
Augusta, Georgia, May 1-4, 1955

President's Invitation

A MOST CORDIAL INVITATION IS extended to Doctor's wives in Georgia to attend the Thirtieth Anniversary Convention of the Woman's Auxiliary to the Medical Association of Georgia, May 1-4 in Augusta, Ga.

The Bon Air Hotel will be Headquarters for registration and the sessions will be held at the Parish House of the Church of the Good Shepherd near the Hotel.

Richmond County, our hostess Auxiliary, has made wonderful plans for our pleasure and entertainment which include joint evening functions with our husbands. This Anniversary Convention will be one that none can afford to miss. Plan to attend both general meetings and enjoy the fellowship of the entire Convention.

Cordially yours,

Mrs. Shelley C. Davis
President, Woman's Auxiliary
to the Medical Association of
Georgia



Mrs. Shelley C. Davis

Welcome to Augusta



Mrs. Stewart Flanagin

TO THE MEMBERS OF THE WOMAN'S AUXILIARY to
the Medical Association of Georgia:

The Woman's Auxiliary to the Richmond County Medical Society is pleased to extend to you a cordial welcome to attend the Thirtieth Annual Meeting of the Woman's Auxiliary to the Medical Association of Georgia, which will be held in Augusta, May 1-4, 1955.

Sincerely,

Mrs. Stewart Flanagin
President, Woman's Auxiliary to
the Richmond County Medical
Society

ORGANIZATION

of the

Woman's Auxiliary to the Medical Association of Georgia

Officers and Chairmen

President—Mrs. Shelley C. Davis	Atlanta
President-Elect—Mrs. Robert C. Major	Augusta
First Vice-President—Mrs. W. P. Rhyne	Albany
Second Vice-President—Mrs. Virgil Williams	Griffin
Third Vice-President—Mrs. Joe Arrendale	Cornelia
Recording Secretary—Mrs. W. P. Stoner	Sylvester
Corresponding Secretary—Mrs. Walker Curtis	College Park
Treasurer—Mrs. Loyd Osteen	Savannah
Historian—Mrs. Lester Harbin	Rome
Parliamentarian—Mrs. Bruce Schaefer	Toccoa

Advisory Committee

Dr. Enoch Callaway, <i>Chairman</i>	LaGrange
Dr. Shelley C. Davis	Atlanta
Dr. W. G. Elliott	Cuthbert
Dr. Willard R. Golsan	Macon
Dr. Bruce Schaefer	Toccoa
Dr. Peter B. Wright, <i>ex officio</i>	Augusta

Standing Committee Chairmen

Achievement Award—Mrs. T. A. Sappington	Thomaston
Archives—Mrs. E. A. Bancker	Atlanta
American Medical Education Foundation— Mrs. Luther Wolff	Columbus
Budget and Finance—Mrs. J. R. S. Mays	Macon
Browner Trophy—Mrs. Leo Smith	Waycross
Bulletin—Mrs. W. U. Hyden	Trion
Civil Defense—Mrs. John I. Hall	Macon
Doctors' Day—Mrs. Edgar Dunstan	Decatur
Editorial—Mrs. Ted Leigh	Atlanta
Legislation—Mrs. Edwin Rushia	Augusta
Mental Health—Mrs. Richard Winston	Valdosta
Nurse Recruitment—Mrs. C. J. Roper	Jasper
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Program—Mrs. W. P. Rhyne	Albany
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Research and Romance of Medicine— Mrs. E. V. Patrick	Carrollton
Revisions—Mrs. W. G. Elliott	Cuthbert
Safety—Mrs. D. L. Burns	Valdosta
Scrap Book—Mrs. Joe Arrendale	Cornelia
Student Loan Fund—Mrs. William Boyd	Augusta
Today's Health—Mrs. Virgil Williams	Griffin

Special Committee Chairmen

Hall of Fame—Mrs. Olin S. Cofer	Atlanta
State Hand Book—Mrs. Ralph Fowler	Marietta

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First District—Mrs. Louis Griffin	Claxton
Second District—Mrs. Robert E. Jones	Tifton
Third District—Mrs. W. B. McMath	Americus
Fourth District—Mrs. Virgil Williams	Griffin
Fifth District—Mrs. Christopher McLoughlin	Atlanta
Sixth District—Mrs. Joseph Lever	Sandersville
Seventh District—Mrs. Charles Richards	Calhoun
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Tenth District—Mrs. Hubert Milford	Hartwell

County Auxiliary Presidents

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Calhoun-Early-Miller (Tri County)—Mrs. J. H. Crowdis	Blakely
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Cobb—Mrs. Charles Garland	Smyrna
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Floyd—Mrs. William Brooks	Rome
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Hall—Mrs. Ben Gilbert	Gainesville
Jackson-Barrow—Mrs. A. B. Russell	Winder
Lowndes-Lanier-Berrien-Cook-Clinch	

(Aux. to So. Ga. Med. Soc.)—Mrs. F. G. Eldridge	Valdosta
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Washington—Mrs. Joseph Lever	Sandersville
Whitfield—Mrs. Loyd Yeargin	Dalton
Worth—Mrs. H. G. Davis	Sylvester

Past Presidents and Conventions

Honorary Presidents for Life

Mrs. James N. Browner, Sr., Atlanta
Mrs. Eustace A. Allen, Atlanta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta, Temporary Chairman.
1925—Atlanta—Mrs. James N. Browner, Sr., Atlanta
1926—Albany—Mrs. William H. Myers, Savannah
1927—Athens—Mrs. C. W. Roberts, Atlanta
1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S. C.)
1929—Macon—Mrs. Charles C. Hinton, Macon
1930—Augusta—Mrs. Marion T. Benson, Atlanta
1931—Macon—Mrs. Charles C. Harrold, Macon
1932—Savannah—Mrs. Ralston Lattimore, Savannah
1933—Macon—Mrs. S. T. R. Revell, Louisville
1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)
1935—Atlanta—Mrs. J. E. Penland, Waycross
1936—Savannah—Mrs. Ernest R. Harris, Winder
1937—Macon—Mrs. W. R. Dancy, Savannah
1938—Augusta—Mrs. Ralph Chaney, Augusta
1939—Atlanta—Mrs. Warren A. Coleman, Eastman
1940—Savannah—Mrs. Eustace A. Allen, Atlanta
1941—Macon—Mrs. W. G. Banister, Rome
1942—Augusta—Mrs. Lee Howard, Savannah
1943—Atlanta—Mrs. J. Lon King, Macon
1944—Savannah—Mrs. Olin S. Cofer, Atlanta
1945—No convention
1946—Macon—Mrs. W. T. Randolph, Winder
1947—Augusta—Mrs. Bruce Schaefer, Toccoa
1948—Atlanta—Mrs. W. G. Elliott, Cuthbert
1949—Savannah—Mrs. S. A. Anderson, Atlanta
1950—Macon—Mrs. J. Harry Rogers, Atlanta
1951—Augusta—Mrs. Lehman W. Williams, Savannah
1952—Atlanta—Mrs. J. R. S. Mays, Macon
1953—Savannah—Mrs. Ralph Fowler, Marietta
1954—Macon—Mrs. Leo Smith, Waycross

CONVENTION COMMITTEES

Woman's Auxiliary to the Richmond County Medical Society—Hostess

Mrs. Nathan DeVaughn, *General Chairman*
Mrs. M. H. Wylie, *General Co-chairman*

Credentials and Registration

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Mrs. Pomeroy Nichols, Jr., *Co-chairman*

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Mrs. William A. Wilkes	Mrs. Enon C. Hopkins
Mrs. R. A. Krouse	Mrs. Leo H. Pou
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Mrs. J. B. Bowen	Mrs. David C. Williams
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Mrs. Hayward Phillips	Mrs. J. P. Hitchcock
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Mrs. S. Schwartz	

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Mrs. W. D. Jennings, Jr.

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Mrs. Louis L. Battey	Mrs. S. M. Roberts
Mrs. Jack Bell	

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Mrs. G. L. Kelly	Mrs. W. A. Fuller
Mrs. T. C. Thompson	Mrs. E. Q. Hull
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Mrs. Rufus Payne	Mrs. C. H. Thigpen
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Mrs. W. K. Philpot	Mrs. E. S. Sanderson
Mrs. R. L. Rhodes	

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Mrs. P. P. Volpito	Mrs. F. Lansing Lee
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Mrs. E. K. McLain	Mrs. K. W. Milligan
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Mrs. Harry T. Harper	Mrs. R. G. Ellison
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Mrs. F. G. Stephens	

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Mrs. M. B. Bell, *Co-chairman*

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Mrs. B. L. Redd	

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Mrs. G. M. Kelly, *Chairman*

Mrs. C. H. Carter, *Co-chairman*

Mrs. C. I. Bryans Mrs. G. Holmstock

Pre-convention Executive Board Luncheon Post-convention Executive Board Breakfast

Mrs. H. B. O'Rear, *Chairman*

Mrs. D. Frank Mullins, Jr., *Co-chairman*

Mrs. J. E. Hummel

Past Presidents Luncheon

Mrs. Ralph Chaney, *Chairman*

Tea

Mrs. C. W. Hock, *Chairman*

Mrs. J. R. Rinker, *Co-chairman*

Mrs. Richard Torpin	Mrs. W. F. Hamilton, Jr.
Mrs. F. N. Harrison	Mrs. A. T. Murphy
Mrs. J. M. Martin	Mrs. Jack Hudson

Luncheon and Fashion Show

Mrs. B. C. Beard, *Chairman*

Mrs. W. O. White, *Co-chairman*

Mrs. M. B. Sell	Mrs. H. D. Pinson
Mrs. C. C. Smith	Mrs. D. E. Turner

Social Hour and President's Dinner

Mrs. H. R. Perkins, *Chairman*

Mrs. A. J. Waters, *Co-chairman*

Mrs. L. P. Holmes	Mrs. J. B. Bohorfoush
Mrs. M. N. Wolcott	Mrs. R. A. Krouse
Mrs. C. M. Rhode	

Memorial

Mrs. Stewart Flanagan Mrs. C. I. Bryans, Jr.

Time Keepers

Mrs. John Durden, Columbus	Mrs. G. H. Perrow, Jasper
Mrs. F. G. Eldridge, Valdosta	Mrs. Q. R. Pirkle, Decatur

Tellers

Mrs. J. M. Kellum, Thomaston	Mrs. Chas. Watt, Jr., Thomasville
Mrs. T. E. Reeve, Jr., Carrollton	Mrs. Neal Yeomans, Waycross

Courtesy

Mrs. A. Worth Hobby, Atlanta Mrs. A. B. Russell, Winder

Resolutions

Mrs. H. M. Smith, Savannah Mrs. Wilbur Scott, Milledgeville

Reading

Mrs. Ted Leigh, Atlanta	Mrs. W. B. McMath, Americus
Mrs. Bruce Schaefer, Toccoa	Mrs. Charles Garland, Marietta

Awards

Achievement

Mrs. T. A. Sappington, Thomaston, *Chairman*
Mrs. W. G. Elliott, Cuthbert
Mrs. Ralph Chaney, Augusta

Browner Trophy

Mrs. Leo Smith, Waycross, *Chairman*
Mrs. Ralph Fowler, Marietta
Mrs. J. R. S. Mays, Macon

Doctors' Day

Mrs. Edgar Dunstan, Decatur, *Chairman*
Mrs. Guy Adams, Atlanta
Mrs. John E. Porter, Savannah

J. Bonar White Scrap Book

Mrs. Joe Arrendale, Cornelia, *Chairman*
Mrs. Virgil Williams, Griffin
Mrs. W. P. Rhyne, Albany

The Program

30th Anniversary Convention

Headquarters—Bon Air Hotel
Registration—Main Corridor, First Floor, Bon Air Hotel
General Meeting and Exhibits — Good Shepherd Church Parish House
One Block West of Bon Air Hotel on Walton Way

Sunday, May 1

11:00 REGISTRATION

To

6:00 *Bon Air Hotel, Main Corridor*

1:00 PRE-CONVENTION EXECUTIVE BOARD MEETING DUTCH LUNCHEON

Bon Air Hotel Coffee Shop

PRESIDING

Mrs. Shelley C. Davis, President

5:00 JOINT MEETING MEDICAL ASSOCIATION HOUSE OF DELEGATES AND WOMAN'S AUXILIARY

Crystal Room, Bon Air Hotel

PRESIDING

Peter B. Wright, Augusta, MAG President

MAG ORDER OF BUSINESS (*See MAG Delegates Handbook*)

IT'S YOUR AMERICAN MEDICAL ASSOCIATION

George F. Lull, Chicago, Secretary-General
Manager, American Medical Association

AUXILIARY PRESIDENT'S REPORT

Mrs. Shelley Davis, Atlanta, Aux. President
BETTER HEALTH COUNCIL OF GEORGIA PRESIDENT'S REPORT

Mrs. Bruce Schaefer, Toccoa, Better Health
Council President

7:30 SOCIAL HOUR AND DUTCH TREAT BUFFET SUPPER (For Auxiliary Convention Members, Dress Optional)

Augusta Country Club, Walton Way

Monday, May 2

9:00 REGISTRATION

To

5:00 *Bon Air Hotel, Main Corridor*

10:00 GENERAL MEETING

Church of the Good Shepherd Parish House
(One block west of Bon Air Hotel on Walton
Way)

CALL TO ORDER

Mrs. Shelley C. Davis, Atlanta, Aux. President

INVOCATION

The Rev. Allen B. Clarkson, Augusta, Rector
of the Church of the Good Shepherd

PLEDGE OF LOYALTY

Mrs. J. Harry Rogers, Atlanta

WELCOME

Mrs. Stewart Flanagan, President, Woman's
Auxiliary to the Richmond County Medical
Society

RESPONSE

Mrs. W. U. Hyden, Trion

INTRODUCTION OF HONOR GUESTS AND PAST
PRESIDENTS

Mrs. Eustace A. Allen, Atlanta

PRESENTATION OF CONVENTION PLANS AND
CHAIRMEN

Mrs. Nathan DeVaughn, Augusta, General
Chairman

INTRODUCTION OF PAGES FOR THE DAY

Mrs. J. B. Bowen, Augusta, Chairman

REPORT OF ADVISORY COMMITTEE TO THE
WOMAN'S AUXILIARY TO THE MEDICAL ASSO-
CIATION OF GEORGIA

Dr. Enoch Callaway, LaGrange, Chairman

GREETINGS

Dr. Peter B. Wright, Augusta, President, Medi-
cal Association of Georgia

INTRODUCTION OF GUEST SPEAKER

Mrs. Robert C. Major, Augusta, President-
Elect

ADDRESS

Mrs. George Turner, El Paso, Texas, Presi-
dent, Auxiliary to the American Medical As-
sociation

BUSINESS SESSION

CONVENTION RULES OF ORDER

Mrs. Bruce Schaefer, Toccoa, Parliamentarian

ROLL CALL AND MINUTES

Mrs. W. P. Stoner, Sylvester, Recording Sec.

REPORTS

PRESIDENT

Mrs. Shelley C. Davis, Atlanta

PRESIDENT-ELECT (*Presentation of New Aux-
iliaries*)

Mrs. Robert C. Major, Augusta

TREASURER (*Including Report of Auditor*)

Mrs. Loyd Osteen, Savannah

COMPLETE REPORTS (See 1954-55 Annual Re-
port)

RECOMMENDATIONS OF EXECUTIVE BOARD

NEW BUSINESS

REVISIONS

Mrs. W. G. Elliott, Cuthbert, Chairman

REPORT OF CREDENTIALS COMMITTEE

Mrs. Robert Crichton, Augusta, Chairman

1:00 DUTCH LUNCHEON FOR PAST PRESIDENTS
Penthouse, Bon Air Hotel
 PRESIDING
 Mrs. Leo Smith, Waycross, Immediate Past President

4:00 TEA—Sponsored by the Woman's Auxiliary to the Richmond County Medical Society (For Auxiliary Convention Members)
Garden Center (Old Medical College of Georgia, Telfair St. Transportation provided from front of Bon Air Hotel
 RECEIVING
 Mrs. Stewart Flanagan, Augusta, Richmond County Aux. President
 Mrs. Shelley Davis, Atlanta, MAG Aux. Pres.

Mrs. George Turner, El Paso, Texas, AMA Aux. President
 Mrs. Lewis K. Hundley, Pine Bluff, Ark., SMA Aux. President
 Mrs. Robert C. Major, Augusta, MAG Aux. President-Elect
 Mrs. Peter B. Wright, Augusta, Wife, MAG President
 Mrs. Nathan DeVaughn, Augusta, General Chairman for Convention
 Mrs. M. H. Wylie, Augusta, General Chairman for Convention

7:30 ALUMNI DINNERS (For Auxiliary Convention Members, Dress Optional)
Place and Time to Be Announced

Tuesday, May 3

9:00 REGISTRATION
 To
12:00 Bon Air Hotel, Main Corridor

10:00 GENERAL MEETING
Church of the Good Shepherd Parish House, Walton Way
 CALL TO ORDER
 Mrs. Shelley Davis, Atlanta, Aux. President
 INVOCATION
 Mrs. J. Lon King, Macon
 PLEDGE OF LOYALTY
 Mrs. Lee Howard, Sr., Savannah
 INTRODUCTION OF PAGES FOR THE DAY
 Mrs. W. A. Wilkes, Augusta
 ANNOUNCEMENT—CONVENTION PLANS
 Mrs. M. H. Wylie, Augusta, General Convention Co-Chairman
 PRESENTATION OF AUXILIARY TO THE SOUTHERN MEDICAL ASSOCIATION, DOCTORS' DAY AWARD AND INTRODUCTION OF GUEST SPEAKER
 Mrs. W. P. Stoner, Sylvester, Councilor to SMA from Georgia
 ADDRESS
 Mrs. Lewis K. Hundley, Pine Bluff, Arkansas, President, Woman's Auxiliary to the Southern Medical Association
 THE MEDICAL ASSOCIATION OF GEORGIA AND ITS AUXILIARY IN 1955-56
 H. Dawson Allen, Milledgeville, MAG President-Elect

BUSINESS SESSION
 ROLL CALL AND MINUTES
 Mrs. W. P. Stoner, Sylvester, Recording Secretary
 REPORT OF REVISIONS COMMITTEE
 Mrs. W. G. Elliott, Cuthbert, Chairman
 REPORT OF BUDGET AND FINANCE COMMITTEE
 Mrs. J. R. S. Mays, Macon, Chairman
 REPORT OF RESOLUTIONS COMMITTEE
 Mrs. Harold M. Smith, Savannah, Chairman
 REPORT OF THE CREDENTIALS COMMITTEE
 Mrs. Robert Crichton, Augusta, Chairman

REPORT OF THE COURTESY COMMITTEE
 Mrs. A. Worth Hobby, Atlanta, Chairman
 REPORT OF AWARDS COMMITTEE
 Achievement—Mrs. T. A. Sappington, Thomaston, Chairman
 Doctors' Day—Mrs. Edgar Dunstan, Decatur, Chairman
 J. Bonar White Scrap Book—Mrs. Joe Arrendale, Cornelia, Chairman
 Brawner Trophy for General Excellence—Mrs. Leo Smith, Waycross, Chairman
 REPORT OF NOMINATING COMMITTEE
 Mrs. Ralph Fowler, Marietta, Chairman
 ELECTION OF OFFICERS
 INSTALLATION OF OFFICERS
 Mrs. George Turner, El Paso, Texas, President, Woman's Auxiliary to the American Medical Association
 PRESENTATION OF PRESIDENT'S PIN
 Mrs. Shelley Davis, Atlanta, Retiring President
 INAUGURAL ADDRESS—ANNOUNCEMENT 1955-56 CHAIRMEN
 Mrs. Robert C. Major, Augusta, President
 PRESENTATION OF PAST PRESIDENT'S PIN
 Mrs. Joseph Yampolski, Atlanta
 ANNOUNCEMENTS
 ADJOURNMENT

1:00 LUNCHEON-FASHION SHOW (For Auxiliary Convention Members)
Augusta Country Club (Transportation provided from front of Bon Air Hotel)
 PRESIDING
 Mrs. Shelley Davis, Atlanta

7:00 SOCIAL HOUR, Sponsored by Richmond County Medical Society (For Auxiliary Convention Members)
Veranda, Bon Air Hotel

8:00 PRESIDENT'S DINNER (For Auxiliary Convention Members, Dress Optional)
Crystal and Plantation Rooms, Bon Air Hotel

**9:30 POST CONVENTION EXECUTIVE BOARD
MEETING DUTCH BREAKFAST (1955-56
Officers, Chairmen, District Managers,
County Presidents and State Past-Presidents)**

Oglethorpe Lounge, Bon Air Hotel

PRESIDING

Mrs. Robert C. Major, Augusta, President

**10:00 WOMAN'S AUXILIARY AND MEDICAL
ASSOCIATION OF GEORGIA JOINT
MEMORIAL SERVICE**

Crystal Room, Bon Air Hotel

PRESIDING

Peter B. Wright, MAG President

INVOCATION

Rev. Charles Schilling, Rector St. Paul's Episcopal Church, Augusta

IN MEMORIAM

MEDICAL ASSOCIATION OF GEORGIA

Dr. Enoch Callaway, LaGrange

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Mrs. Stewart Flanagan, Augusta

Mrs. C. I. Bryans, Jr., Augusta

**10:30 JOINT GENERAL BUSINESS SESSION (All
MAG and Auxiliary Members and Guests)**
Crystal Room, Bon Air Hotel

PRESIDING

Peter B. Wright, Augusta, MAG President

PRESENTATION OF 50-YEAR CERTIFICATES

PRESENTATION OF HARDMAN AWARD

PRESENTATION OF CERTIFICATES OF APPRECIATION

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS

PRESENTATION OF PRESIDENT'S KEY

GOLF PRIZE AWARDS

SELECTION OF 1956 ANNUAL SESSION MEETING PLACE

ELECTION RESULTS

INSTALLATION OF NEW OFFICERS

Pledge of Loyalty

to the

Woman's Auxiliary

to the

Medical Association of Georgia

I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of Georgia. I will support its activities, protect its reputation, and ever sustain its high ideals.

Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed.

Let us be done with fault-finding and leave off selfseeking.

May we put away all pretense, and meet each other face to face without self-pity and without prejudice.

May we never be hasty in judgment, and always generous.

Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid.

Grant that we may realize it is the little things that create differences; that in the big things of life we are one.

And may we strive to reach and to know the great common woman's heart of us all, and, O, Lord God, let us not forget to be kind."

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general sessions of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by the persons making and seconding the motion.
7. All original motions on resolutions shall be made by submitting two copies, one to the Resolutions Committee and one to the Recording Secretary.
8. All persons appearing on the program must be seated near the platform when the session opens.

Whispering conversations greatly retard the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

NOTE: Tickets are available at Registration Desk to Auxiliary Convention Members for (1) Sunday Evening Social Hour and Dutch Treat Buffet Supper, Augusta Country Club, Walton Way, (2) Monday Past President's Luncheon, Pent House, Bon Air Hotel (Past Presidents

Only), (3) Monday Afternoon Tea, Garden Center, Old Medical College of Georgia Bldg., Telfair Street, (4) Tuesday Luncheon-Fashion Show, Augusta Country Club, Walton Way, and (5) Tuesday Evening President's Dinner, Crystal and Plantation Rooms, Bon Air Hotel.

Surgical Treatment of Stress Urinary Incontinence in Women

JOHN H. RIDLEY, M.D., Atlanta, Ga.

STRESS URINARY INCONTINENCE may be defined as the involuntary loss of urine due to the increased intravesical pressure by normally tolerated stress. Through the years, every type of therapeutic effort has been made to correct this troublesome condition, but it has long been accepted that surgery must be resorted to in the great majority of cases. Although this paper will deal particularly with the surgical consideration for correction, other types of therapy, that have been tried and are at the present being tried, will be mentioned for interest.

This condition may exist in varying degrees and has arbitrarily been classified as mild, moderate, marked and complete. At this time, differentiation should be made between this incontinence per urethrum and the urinary incontinence which may exist with the vesico-vaginal or ureterovaginal or urethro-vaginal fistula. Surprisingly, large numbers of cases are seen in both private practice and clinics that will tolerate mild and moderate stress incontinence without complaint. They assume perhaps that it is probably a price to pay for childbearing or that an operation for its correction would not be justified. The presence of a troublesome amount of this incontinence is sometimes discovered only by direct questioning, because some patients are seemingly hesitant to volunteer the information. At any rate, the direct question of the possibility of its existence should be included in every genito-urinary history.

The chief etiologic factors are listed below in the order of their importance: (a) childbirth trauma, (b) postoperative cicatrix, (c) congenital weakness and senility, (d) neurogenic disturbances, (e) infections, (f) sometimes transient in pregnancy.

Injuries sustained at childbirth account for the great majority of cases of stress urinary incontinence usually accompanied by a demonstrable cystocele or cystourethrocele. Childbirth trauma has been variously reported as being accountable in between 85 and 90 per cent of the cases of stress urinary incontinence. The weakness of the sphincter muscle is due to the direct trauma to the smooth muscle envelope of the urethra and bladder neck and to the stretching and tearing of the fascia, locally, and of that lending direct support to the bladder neck. Depending both on the amount of injury and the age of the patient,

the incontinence may develop immediately after delivery or may develop over a period of months or years, depending on the integrity of the tissues and the amount of increased abdominal pressure over this period of time such as seen in a chronic cough or obesity. This then is a structural failure, and therefore surgery has become more and more extensively used for the reconstruction; this fact should be made known to the patient. In some cases, however, if the incontinence is so troublesome as to cause constant discomfort and embarrassment, repair is indicated, even though it may be jeopardized by subsequent delivery. However, it is not a foregone conclusion that delivery will completely tear down the controlled gain; in fact, some cases proceed through subsequent pregnancies without recurrence of their stress incontinence.

Postoperative scarring about the urethra and bladder neck may result in incompetency of the sphincter mechanism. This condition may follow an otherwise satisfactory anterior colporrhaphy where no previous stress incontinence of urine had existed. Although this is not frequently seen, it is a disappointing and troublesome condition to develop. Because of this possibility of scarring, the practice of a prophylactic plication of the bladder neck is not indicated where stress incontinence does not exist.

We see that a few cases of muscular and fascial weakness of a congenital nature are due to the atrophy and weakening in senility. This type of stress incontinence is more disappointing to deal with because of the existence of poor tissues to use in the attempt at repair. The percentage of failures is relatively higher in this smaller group.

A few instances of neurogenic weakness of the bladder neck are seen, but usually there is an accompanying weakness of the entire bladder. This should be thoroughly evaluated by a study of the bladder dynamics by cystometric studies. If the bladder is found to be weakened, the condition may be greatly aggravated by developing, surgically, a controlled bladder neck "obstruction."

Review of the history of the therapeutic attempts show that the following besides surgery have been tried.

(a) Drugs of various sorts that might cause an

increased tone of the smooth musculature such as strychnine or prostigmine; if these gave any effect it was only transient and are now not used.

(b) Mechanical aids such as variously designed pessaries and tampons have been tried, particularly in aged individuals where surgery would be contra-indicated.

(c) Physiotherapeutic means such as exercises, hot and cold hydrotherapy and Galvanic stimulation of the bladder neck have been tried, but only the use of exercises has proven to be of value. In 1948, Kegel,¹ at the University of Southern California School of Medicine, outlined a regimen for strengthening the perineal musculature by exercises. Numerous reports of definitely encouraging results have been published since that time about the use of exercises to strengthen the contractile ability of the pubococcygeus muscles. However, if this supporting musculature and fascia is not anatomically intact these exercises would naturally be futile.

Minor surgical efforts of varying types have been tried such as cauterization of the internal and external meatus in the hope that there would be some contraction. Even periurethral injections of sclerosing agents such as sodium morrhuate or paraffin have been tried, but these were all unsatisfactory.

It has finally been conclusively shown that adequate and appropriate surgical intervention gives the most dependable chance for correction of stress incontinence.

Principles of Surgical Correction

Surgery limited to the tissues about the urethra and/or the bladder neck is the principle used in the great majority of cases. It, as a matter of fact, with only a few exceptions, gives the primary choice for the surgical intervention. Most of the procedures that will be discussed in the following paragraphs have their indications limited to failures of the simpler procedures of plication and reconstruction about the bladder neck. The most commonly used procedure is that devised by H. A. Kelly,² in 1912, which consists of exposure of the entire urethra, including the bladder neck and plication of the periurethral tissues with interrupted mattress sutures on non absorbable material. (Figure 1)

To facilitate the location of the bladder neck, a mushroom or Foley bag catheter is inserted in the bladder and drawn gently until it impinges at the internal sphincter. As the mattress sutures are tied, the intervening tissue is gently tucked inward. The final suture over the region of the internal sphincter itself is extended to fashion a semi-purse string extending slightly back on the area underlying the trigone. The small catheter (number 14 or 16 French) is allowed to remain in for approximately 48 hours postoperatively. Some difficulty in voiding

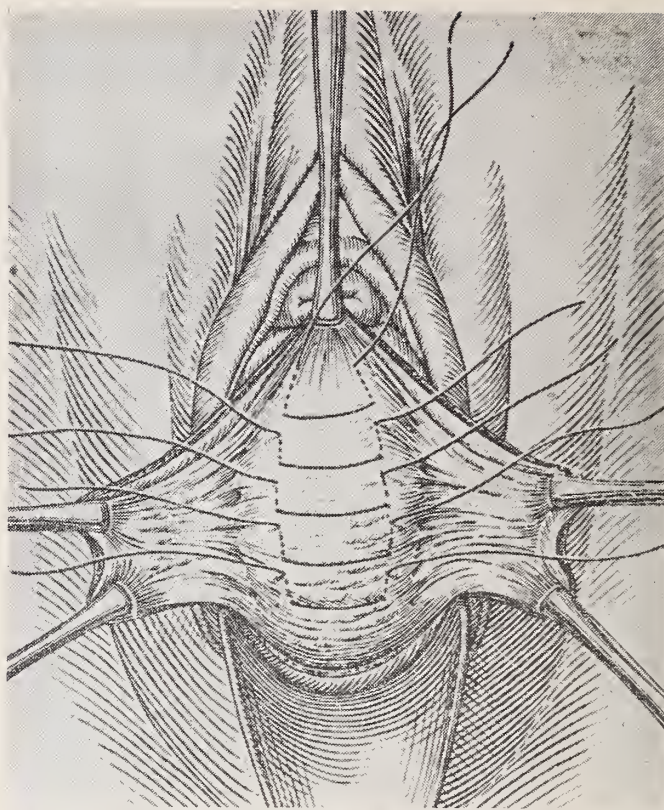


Fig. 1. Plication of urethra by Kelly technique. *Telinde operative Gynecology*, Lippincott.

may be experienced by the patient at first, but this usually subsides as the edema of the operation subsides. The success of this procedure has been variously reported: from 60 to 80 per cent satisfactory results. At the Johns Hopkins Hospital,³ in Baltimore, the results have been called satisfactory in between 75 and 80 per cent of cases.

A Kennedy type of variation of the Kelly plication is sometimes resorted to, particularly in those cases in which there has been periurethral scarring from previous operation or obstetrical damage. In this procedure the periurethral tissues are dissected away to expose the urethra in two-thirds of its circumference and practically its entire length. Thus the plication enfolds more of the urethra and with the interruption of scar tissue by dissection, gives the periurethral tissues a chance to heal again about the plicated structure.

Another type of operation generically classified as "sling" procedures is used in those cases where simple plication has failed or in those individuals, such as the aged, with poor tissues where it would be thought that the use of the tissues about the bladder neck would be useless and unsuccessful. Also in certain cases of neurogenic disturbances with weakness about the bladder neck, the sling operation of some type may be used. The principle of this procedure is to reestablish the angle of the trigone with the urethra to the normal state. The existence of a disturbance of this angle has been clearly demonstrated by Jeffcoate⁴ by the use of radiography.

The choice of the material selected for use in forming the supporting sling depends on the operator and the condition of the tissues of the patient. In 1907, Giordano⁵ first used a sling fashioned from the juxtaposed gracilis muscles and actually is the father of the sling operation. However, Goebell⁶ in 1910 used the pyramidalis muscles to form a sling beneath the urethra after these muscles had been dissected free, split and passed beneath the urethral neck. Since 1910, there have been many variations and modifications including the use of the anterior rectus fascial strip with the pyramidalis muscles, by Frangenheim;⁷ with plication of the bladder neck, by Stoeckel⁸ in 1917. In 1942, Aldridge used strips of fascia from the aponeurosis and paralleling the inguinal ligament. Studdiford in 1944 preferred to use one long vertical strap developed from the mid-line fascia necessitating a long abdominal incision. (Figure 2)

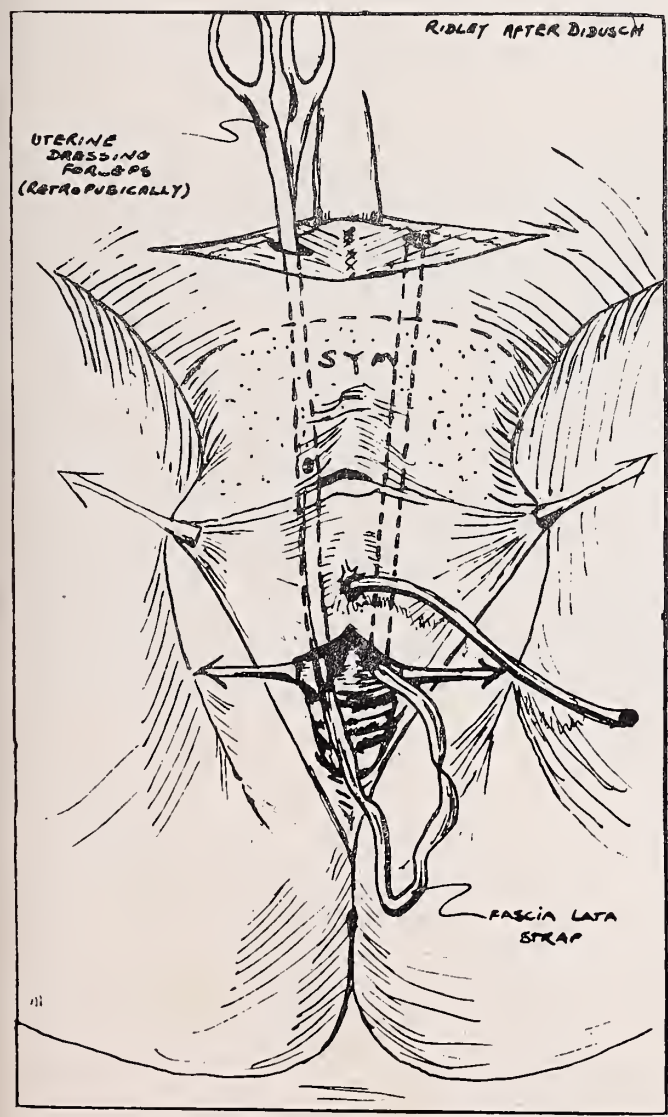


Fig. 2. The strap of fascia lata is being passed retropubically beneath the bladder neck and with either end anchored to anterior rectus fascia.

And in 1947, Millen with Read used two complete transverse straps developed in the manner of the Aldridge modification but from the entire width of the lower abdominal wall.

Other autogeneous materials have been tried, and use of the fascia lata introduced in 1933 by Price⁹ has been the most widely used in this type of tissue.

Some heterogenous materials, such as ox fascia, ox pericardium or kangaroo tendon, have been used but without much success, because of the troublesome foreign body reaction usually set up and the resulting failure of the sling to "take."

And finally, some foreign bodies such as tantalum mesh or polyethylene ribbon have been tried with some success, but as yet they have not been used in enough clinical trials reported to prove themselves worthy.

There have been some variations of technique of placement of the sling. For a number of years now the accepted mode of placement of the sling has been retropubically through the space of Retzius and beneath the urethra. (Figure 3.) In 1932, Norman

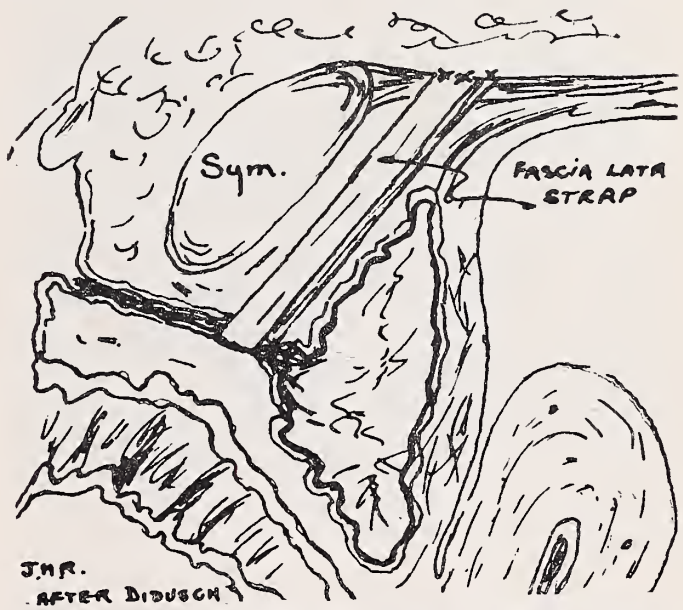


Fig. 3. Sagittal section showing position of strap beneath the bladder neck.

Miller¹⁰ attempted to use the fascial strap developed from the anterior abdominal wall placed antepubically then beneath the urethra. This was not successful because of the improper angle of support and the stripping action of the fascia on the urethra. The chief reason apparently that this was tried was to avoid the sometimes troublesome bleeding that is incurred in the space of Retzius in the plexus of veins about the bladder neck. However, this is, as a rule, not troublesome if blunt dissection is used with minimum trauma. If hemorrhage is encountered in this area usually gentle pressure over these sinuses will satisfactorily control it.

The third principal of surgical intervention in stress urinary incontinence is the procedure of repositioning the urethra and bladder neck to a more normal or exaggerated retropubic position.

In 1949, Marshall and Marchetti¹¹ popularized the "pin up" operation in which proceure the urethra, in practically its entire length, is brought up and fastened to the posterior surface of the symphysis pubis. The immobilizing sutures are placed in the periurethral tissues and periosteum of the pubis, successively superiorly until the anterior surface of the urethra and bladder neck lie closely immobilized against the bone and the lower abdominal wall. (Figure 4) Prior to the election to use this "pin up" operation the patient should be carefully selected particularly using this simple test:

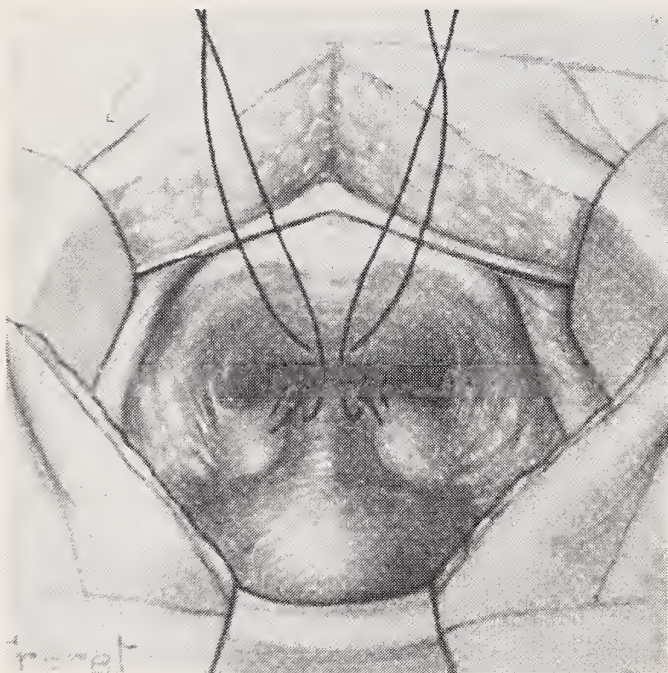


Fig. 4. View of retropubic space from above showing placement of "pin up" suture from paraurethral tissue to periosteum of pubis.

The bladder is filled with approximately 250 to 300 cc. of water slightly colored with methylene blue, and a small wheal is raised in the anterior vaginal wall with novocaine at the site underlying the neck of the bladder. Now the patient, in an erect position, is asked to cough. If, after several trials, by this simple test the stress incontinence is corrected, it may be assumed that such permanent repositioning of the urethra by the Marshall-Marchetti procedure would effect a cure.

This operation has been particularly convenient in those cases with troublesome stress urinary incontinence without too great a cystocele or urethrocele and in which there is also some coexisting intra-abdominal pathology. It can thus be done in conjunction with the abdominal exploration.

Other procedures have been tried in the past, and some necessarily selected at the present, depending on what the individual case demands. One procedure of interest which never gained popularity was that used by Gersuny, in 1889, in the early era of surgical attempts. This surgeon after skeletonizing the urethra rotated it through an arc of 450 degrees in three operations, finally giving the urethra enough torsion to prevent leakage, but at the same time causing difficulty in completely emptying the bladder. Needless to say in a few cases that were tried subsequently, there occurred some sloughing of the urethra and failure of the operation.

The gynecologist or urologist will finally select for most of his cases that procedure with which he has had best individual results. Although there is no one procedure which will correct all cases, we are left with a fairly wide selection of secondary choices. For instance, TeLinde has come to favor the Aldridge modification of the Goebel-Stoeckel operation and reports a high percentage of successful efforts. Therefore permit me to outline our succession of choices in Atlanta, on the Ob-Gyn service of the Emory University School of Medicine at Grady Hospital, and in private practice. As was stated previously the primary choice in our hands has been the simple plication of the vesical neck using the Kelly stitches with non-absorbable sutures. If this technique fails, or if there is the rare case where such procedure is not indicated, there has been about an equal division of choice of a type of sling operation and of choice of the Marshall-Marchetti operation. In those cases in which the use of a sling is made, we have made use of the fascia lata strip obtained from the patient at the time of the remainder of the operation. We have been satisfied with this technique for the following reasons:

(a) Thus far, there have been no complications in obtaining the fascia lata strip nor any cases of complete failure although, as Figure 6 will show, there have been two that obtained only moderate relief.

(b) The abdominal incision is limited to a small suprapubic incision approximately three inches in length rather than the very wide incisions needed either for the Studiford or the Aldridge modifications.

(c) The anterior abdominal fascial sheath is not incised for any great length but simply perforated to allow passage and fixation of the fascia lata strip. Thus the patient runs no risk of postoperative hernia in the inguinal or the midline regions. Also the ambulation and convalescence of the patient is materially shortened.

(d) The amount of tension desired to be placed on the fascia sling is more easily controlled with the continuous sling rather than the attempt to control

the two loose ends of the abdominal fascia which would be passed and joined beneath the urethra.

(e) The scar on the leg need not be over three centimeters in length. This incision is made just beneath the greater trochanter of the femur through which the adequate fascia lata strip can be removed with the Masson stripper which is passed beneath the tissues to cut the strip at the external epicondyle of the femur.

(f) It is an easy matter to perform any necessary anterior colporrhaphy as may be indicated in conjunction with this procedure.

In performing the retropubic fixation of the urethra and the bladder neck in the Marshall-Marchetti procedure, it was found that the part of the mattress suture which is placed in the periureteral tissues could be more easily placed by using a "boomerang" type needle as devised by Young and used in the perineal prostatectomy. Figure 5 shows a diagram of the placement of the sutures retropubically and the final position of the urethra and bladder neck at the end of the operation. Although one might suspect that there was a condition created to favor a bladder residual, this is not actually true in practice, and bladder drainage is usually complete.

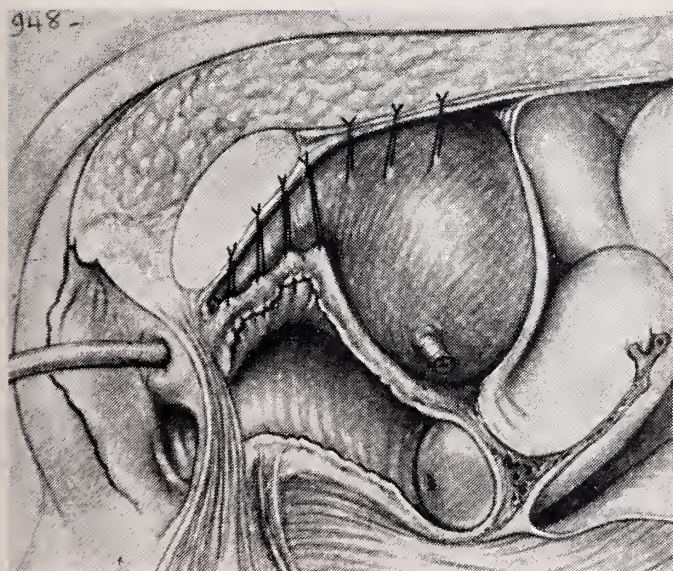


Fig. 5. Final position of urethra and bladder neck in Marshall-Marchetti operation.

There are rare instances in which all effort to control urethral incontinence has failed and more radical procedures must be resorted to. Such procedure would be a bilateral ureterosigmoidostomy where due consideration had been taken of the subsequent danger to the kidneys by retrograde infection. This procedure would be an admission of defeat on the part of the surgeon and indicated only by a situation which had become completely intolerable to the patient.

Occasionally in aged individuals or poor operative

risks a temporizing use of an indwelling urethral catheter is sometimes considered.

The value of transurethral resection of the bladder neck is questionable. Gynecologists and the great majority of urologists report that the practice is not only unsatisfactory but not without danger of establishing a vesicovaginal fistula in the area of the bladder neck.

Material

A survey has been made of the past six years of private practice and of the past five years of the Gyn-Ob service at the Grady Memorial Hospital. There was found a total of 21 cases treated by either a type of sling operation or the Marshall-Marchetti procedure. It was also found incidentally that in five years at the Grady Memorial Hospital there were 147 (120 white and 27 colored) cases treated for stress urinary incontinence by the Kelly type plication procedure. Many of these were part of more extensive plastic operations. Although notations on followup examinations were frequently lacking, in regard to results of the plication, it was obvious that this simple procedure carried the expected high rate of cure.

A detailed study of those cases demanding the more extensive procedures reveals one failure and only tolerable improvement in four. (Figure 6)

The choice of operation has been predominantly the Goebel-Stoeckel Sling procedure with the fascia lata strip.

It will be noted that the great majority of patients is 50 years of age or older. Although there were two cases in nulliparous women, 13 of the 21 cases had had three or more full term deliveries. The degree of incontinence was always marked or complete and in most cases necessitated wearing a constant protection. Seventeen of the 21 cases had had previous surgery specifically for the correction of the stress incontinence of urine, with partial or complete failure of the attempt. In 12 of the 21 procedures, the Goebel-Stoeckel procedure using the fascia lata strap was chosen for reasons outlined previously in this paper. In two cases the Goebel-Stoeckel procedure with the Aldridge strap was selected with essentially satisfactory results, but it was noted in the history of one case that although the stress incontinence was cured, the patient had a resulting small postoperative hernia in the region where the Aldridge strap had been developed. The remaining operations were of the Marshall-Marchetti procedure, being used a total of eight times on seven patients. This procedure was not used until 1950, but it has proven itself to be of definite value. It is believed that the failure of the Marshall-Marchetti procedure noted in the chart was due to the failure of the sutures to hold retropubically. In those cases where the preoperative test was

Name and Age	Parity	Degree of Incontinence	Previous Surgery	Present Operation	Result
B. S. 56	P-4	Complete	Incision and Drainage of suburethral abscess Repair of vesicovaginal fistula	Goebell-Stoeckel with fascia lata strap	Cured
M. P. 39	P-4	Marked	Anterior colporrhaphy with Kelly plication	Goebell-Stoeckel with Aldridge strap	Improved
M. J. 63	P-4	Complete	Anterior colporrhaphy	Goebell-Stoeckel with fascia lata strap	Cured
G. McH. 69	0	Complete	None	Goebell-Stoeckel with fascia lata strap	Cured
B. B. 48	P-5	Complete	Fulguration of bladder neck Goebell-Stoeckel (Aldridge)	Goebell-Stoeckel with fascia lata strap	Improved
S. C. 60	P-4	Marked	Vaginal hysterectomy with A & P colporrhaphy and Kelly plication	Goebell-Stoeckel with fascia lata strap	Cured
M. R. 40	P-4	Marked	Pelvic laparotomy	Marshall-Marchetti "Pin-up" operation and anterior colporrhaphy	Cured
E. A. 40	P-2	Complete	Pelvic laparotomy and anterior colporrhaphy	Marshall-Marchetti "Pin-up" and anterior colporrhaphy right salpingo-oophorocystectomy	Cured
J. A. 52	P-1	Complete	Pelvic laparotomy and Kelly plication with anterior colporrhaphy	Goebell-Stoeckel with fascia lata strap	Cured
D. C. 48	P-3	Marked	Anterior and posterior colporrhaphy with Kelly plication	Marshall-Marchetti "Pin-up" with anterior and posterior repair	Cured
S. C. 60	P-5	Complete	Anterior and posterior colporrhaphy with Kelly plication Anterior colporrhaphy c K. plication	Goebell-Stoeckel with fascia lata strap	Cured
L. C. 66	P-3	Marked	Anterior colporrhaphy with Kelly plication	Goebell-Stoeckel with Aldridge strap	Cured
B. P. 50	P-1	Marked	Anterior and posterior colporrhaphy with Kelly plication	Marshall-Marchetti	Improved
L. A. 66	P-2	Complete	Anterior and posterior colporrhaphy with Kelly plication	Goebell-Stoeckel with fascia lata strap	Cured
B. H. 75*	P-4	Complete	Kelly plication stitches	Marshall-Marchetti operation	Failure
B. H. 76*	P-4	Complete	Marshall-Marchetti	Goebell-Stoeckel with fascia lata strap	Improved
D. B. 31	P-3	Complete	Anterior and posterior colporrhaphy with Kelly plication	Marshall-Marchetti operation and hysterectomy	Cured
G. G. 55	P-2	Marked	Pelvic laparotomy and anterior colporrhaphy with Kelly plication	Goebell-Stoeckel with fascia lata strap	Cured
L. R. 42	P-6	Marked	Vaginal hysterectomy with colporrhaphy and Kelly plication	Goebell-Stoeckel with fascia lata strap	Cured
L. A. 49	P-1	Complete	Pelvic laparotomy and anterior colporrhaphy c Kelly plication	Marshall-Marchetti	Cured
P. D. 64	P-3	Marked		Marshall-Marchetti	Cured
J. T. 50	0	Complete	None	Goebell-Stoeckel with fascia lata strap	Cured
W. D. M. 47	Addendum P-2	Marked	Anterior colporrhaphy with Kelly plication	Goebell-Stoeckel with fascia lata strap	Cured

*Same patient

Fig. 6. (Chart of patients)

made accurately the cases were subsequently found to be cured.

Summary and Conclusions

The troublesome condition of stress urinary incontinence in women is more prevalent than we usually assume, and, on careful questioning in our history taking, it may be found that many women tolerate this troublesome condition thinking that no correctable measure is available.

Historically, it is noted that the first attempts at correction of stress urinary incontinence were begun surgically in 1878 by Schultz.¹² Between that time and the present there have been a large number of procedures with modifications tried. Now three types of surgical approach are accepted: (a) Surgery limited to the urethra and/or the bladder neck. (b) The sling operations, collectively spoken of as the Goebel-Stoeckel procedures using various tissues both autogenous and heterogenous in origin. Although the choices of modification of the operation are numerous, the individual operator will finally come to depend on one particular type that has served him best. In this particular paper the use of the fascia lata strip, as developed first by Price in 1933, has been stressed. The advantages of the use of this material and this procedure have been enumerated. (c) The newer addition to the surgeon's armamentarium for correction of this stress incontinence is the retropubic fixation of the urethra and bladder neck as described by Marshall and Marchetti. This procedure in carefully selected cases has proven itself to be dependable and is enjoying an increasing popularity.

Although other types of therapeutic approaches have been tried, such as Kegel's technique of

strengthening the pubococcygeus muscles, surgery has proven itself to be the treatment of choice in the great majority of cases. This is simply due to the fact that the great majority of cases of stress urinary incontinence in women is due to structural failure sustained at childbirth or tissue failure as seen in some individuals, particularly in the aged.

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Addendum

Since this paper was submitted for publication another case has been surgically treated for marked recurrent stress urinary incontinence. It is briefly outlined:

W. D. M.; 47, P 2, had an anterior colporrhaphy with plication of bladder sphincter and urethra two months prior to first examination. She had marked stress incontinence necessitating wearing constantly a perineal pad. Bladder dynamics were normal. For two months she diligently tried exercises to strengthen the pubococcygeus muscle without improvement. Six months after her original operation a Goebell-Stoeckel operation was performed using a fascia lata strap. During the operation some troublesome retropubic venous bleeding was encountered but controlled by pressure and transfusion. Her postoperative hospitalization was longer than average although there was steady improvement of bladder function. Upon discharge from the hospital she had 30 cc. residual urine but no incontinence. Follow up examination six months postoperatively revealed no residual urine and complete urinary control.

Medicine on the Air

DOCTORS OF AMERICA again will plug better health on the air waves as the AMA's Bureau of Health Education announces its 1955 radio transcription plans. Three new program series will be developed for use by state and county medical societies over local radio stations.

With the cooperation of the Rocky Mountain Radio Council, AMA will make available about April 15 a special series of 13 medical "whodunits" entitled, "Dr. Tim Detective." This series tells the story of two youngsters who help the doctor solve interesting and mysterious medical cases. For example, one involves a criminal who betrays himself because of what he does not know about diabetes.

Another series to be released about June 15 will be based on AMA's week-day Chicago television program, "The Doctor Answers." Tapes will be made of 13 of these shows in which Elizabeth Hart (WBKB-TV women's commentator) asks pertinent health questions of Bureau staff doctors W. W. Bauer (director) and W. W. Bolton.

The final series—dealing with new developments in various medical specialties—will be completed about Sept. 15. Top-flight authorities in such fields as geriatrics, mental health, cancer, polio, arthritis and obstetrics will be featured.

Further details will be announced later.

Retroperitoneal Liposarcomas

TED F. LEIGH, M.D., and JAMES V. ROGERS, JR., M.D., Emory University, Ga.

RETROPERITONEAL LIPOSARCOMAS are malignant fatty tumors of connective tissue origin. They can be diagnosed with reasonable certainty by roentgenographic methods alone if they fulfill the following criteria:

- (1) Having sufficient fat in the tumor to give a relative translucency on the films.
- (2) Having the amount of fat insufficient in extent to account for the whole mass.

Pathology

A brief description of the histopathology of liposarcomas is indicated.

There are two types of fatty tissue tumors—the benign lipoma and the malignant liposarcoma. Lipomas are quite common in the human and occur in many parts of the body. Liposarcomas are less frequent and have a predilection for certain areas, most notably the thighs, gluteal regions, retroperitoneal space, mediastinum and bone. The present communication is concerned only with those originating in the retroperitoneal space.

According to Ackerman¹, liposarcomas are the most common sarcomas of the retroperitoneal space, occurring more frequently than leiomyosarcomas, rhabdomyosarcomas, angiosarcomas, fibrosarcomas and lymphosarcomas.

Liposarcomas are usually quite large in size; Farbman², in a review of 300 cases of both benign and malignant fatty tumors of the retroperitoneal space reported up to 1950, found their average weight to be 7.4 kilograms (16.3 pounds). In their early stages these malignant tumors are well encapsulated, but later they infiltrate the surrounding tissues, including the neighboring organs such as the kidneys, pancreas, liver and stomach.

They apparently arise from a single center, rather than being multi-centric in origin. They arise as a primary malignant tumor and not as malignant degeneration within a benign lipoma.

Liposarcomas present a varied appearance on cut section, depending upon the degrees of fat present; they are soft, yellow and greasy when large quantities of adult fat are present, and hard and white when the tissues are more embryonic in nature.

The microscopic picture is varied. According to Stout³, liposarcomas should be looked upon "not

as a group of separate and distinct tumor types worthy of bearing separate names, but as a single group capable of manifesting different degrees of differentiation which can be indicated by descriptive adjectives." With this concept in mind, he divides them as follows:

- (1) Well-differentiated myxoid types, consisting of adult fat cells and embryonal stellate- or spindle-shaped fat cells bound together by a loose meshwork of connective tissue which is generally, but not always, slimy and myxoid.

- (2) Poorly differentiated myxoid types, which resemble the first group, but with the important difference that the lipoblasts are bizarre and often monstrous, growing to large size with variable nuclear formations.

- (3) Round cell or adenoid types, having rounded cells with centrally placed nuclei and voluminous foamy cytoplasm, the vacuoles of which are filled with only a delicate fibrous framework and an inconspicuous blood supply.

- (4) Mixed types, which contain two or more of the preceding groups.

The growth of liposarcomas may be rapid or slow. They have a great tendency to recur following enucleation, and the characteristics of the recurrent growth may differ widely from those of the original tumor; very commonly the recurrence results in the patient's death.

Liposarcomas are the only ones of the common soft tissue sarcomas which show some degree of radiosensitivity, and in some instances this may be striking.

Case Report 1

Mrs. N. B. D. was a 48 year old married female, who was admitted to the hospital with the chief complaint of swelling of the abdomen of three weeks duration. She had a very vague abdominal discomfort but denied any real pain. Her past and family histories were not remarkable.

Physical examination revealed the presence of a group of lobulated masses in the right mid and lower abdomen. These were firm, slightly movable and non tender. A urinalysis showed four plus albumin.

Roentgenograms of the abdomen revealed the presence in the right abdomen of several fat-containing masses which extended from the level of the liver downward into the right lower quadrant (Figure 1).

On surgical exploration a large retroperitoneal multilobulated mass was found; this filled the right half of the abdomen from the pelvis to the diaphragm and extended several centimeters to the left of the mid line. The mass was totally removed. The medially displaced right kidney was returned to good position. The postoperative course was satisfactory.

The removed specimen weighed 7.5 pounds. The color was generally yellow but quite pale in some areas. It was multilobular, the lobules varying from one to 15 cm. in diameter; some of these were soft and mushy, others fibrous and hard.

*From the Department of Radiology, Emory U. School of Medicine.

Microscopic examination revealed a mixed pattern, some portions of the tumor being definitely sarcomatous with myxomatous elements, others containing normal fat, and still others showing combinations of the two.

The final diagnosis was liposarcoma of the retroperitoneal space.



FIGURE 1A

Case 1. Several large masses are present in the right upper and lower abdomen. The translucent shadows caused by the fat contained in the tumor are visible superiorly. The right kidney is rotated and displaced to the midline. The right ureter in its upper two-thirds is displaced across the midline.

Case Report 2

Mrs. F. S. S. was a 64 year old woman who had noted a progressive increase in the size of her abdomen, over a three month period, and a ten pound weight gain in a similar period. She had no abdominal complaints. There was a long history of diabetes and of cholelithiasis.

Physical examination revealed a grapefruit sized soft mass in the left side of the abdomen. This mass was movable to some extent and was not tender.

Abdominal films made during excretory urography failed to definitely delineate a mass in the left abdomen (Figure 2). There were, however, vague streaks of decreased density in the left upper and mid abdomen, an irregular outline of the left kidney and a medial displacement of the left ureter in its middle third.

At operation, a large solitary mass was found in the lesser peritoneal sac, immediately posterior to the stomach. It appeared to arise from the connective tissue, was somewhat movable and was not fixed to any adjacent organ. By blunt dissection, the tumor was removed.

The gross specimen consisted of two sections, one measuring 30x18x8 cm., and the other 6x4x1.5 cm. Both specimens were nodular, were brilliant yellow and had a greasy consistency.

Microscopically, all sections showed adult fat cells with scattered areas of large spindle shaped cells having irregular and hyperchromatic nuclei.

The final diagnosis was liposarcoma of a very low grade.

Ten months later the patient was readmitted with recurrence of the tumor, and ascites. Masses were felt in both sides of the abdomen. She had a rapid downhill course and died.



FIGURE 1B

A portion of the liposarcoma in the right lower quadrant. Arrows indicate the borders of a large area of fat within the mass. The right colon is markedly displaced to the left.



FIGURE 2

Case 2. The liposarcoma is in the left upper abdomen, but is not well defined. There are translucent areas representing fat within the tumor. Nodular densities are seen adjacent to the upper pole of the kidney. The left ureter in its middle third is displaced medially to a mild extent, probably by the tumor.



FIGURE 3A



FIGURE 3B



FIGURE 3C

FIGURE 3A

Case 3. Initial examination, prior to first operation. The mass is very large, filling the left abdomen, and extending across to the right. Widespread translucent areas are present, which are separated by septa, indicating the presence of lobules of fat. The stomach and small intestine, which contain barium, are markedly displaced to the right.

FIGURE 3B

Retrograde pyelogram from initial examination. The left kidney is rotated, and is displaced superiorly and medially. The left

ureter is displaced to the right throughout its entire course. The lobulated fat is visible, extending from the pelvic region to the left upper quadrant.

FIGURE 3C

Later films, made during patient's final admission. The liposarcoma seen in Figures 3A and B was removed, but has now recurred. One large and several smaller masses are present. The fat content is much less than before. The stomach and intestines are again displaced to the right.

Case Report 3

Mr. B. R. L. was a 56 year old male who had noted a growth in his abdomen for 15 years. On two previous occasions the mass had been surgically excised, but it had recurred. At the time of the second operation peritoneal implants were present. He now had nausea, constipation and increasing shortness of breath.

Physical examination revealed an emaciated male with a very large mass in the abdomen, filling the left flank and extending to the mid line. The superficial veins of the thorax and abdomen were distended.

Roentgenograms made before the first surgery were available; they showed a large mass in the left abdomen, which displaced the abdominal structures to the right (Figure 3A and B). The mass had a relative translucency, indicating the presence of fat, and contained multiple partitions of soft tissue density. Abdominal films 16 months later (Figure 3C), just prior to the present surgery, again revealed multiple masses in the left side. The masses on this occasion contained less translucent areas than were shown on the initial film, indicating lesser contents of fat.

On surgical exploration during this admission, the tumor was found to extend from the diaphragm to the pelvic region; it displaced all abdominal organs to the right. The mass had to be removed in pieces, and its total weight was 18 pounds.

Grossly, the specimen was composed of several irregular large masses. Most of these were yellowish-grey in color and greasy in consistency; microscopic examination of these sections showed them to contain ordinary fat with slight hemorrhage in some areas. Another section, creamy-white in color, showed a highly anaplastic growth, with cells which were generally spindle shaped, and contained numerous mitoses. A few small vacuoles were present.

The final diagnosis was liposarcoma with degeneration.

Case Report 4

Miss S. H. was a 73 year old female who was admitted to the hospital with a recent history of anorexia. She was known to have a moderate hypertension and cholelithiasis. A recent physical examination by her family physician disclosed the presence of a mass in the left abdomen; it had not been palpable on an examination eight months previously.

Physical examination revealed a tumefactive lesion approximately 10x15 cm. in size palpable in the left abdomen. The lesion was hard, non-tender and somewhat movable.

Roentgenograms revealed a large mass in the left abdomen, which extended from the level of the diaphragm downward to the left lower quadrant (Figure 4).



FIGURE 4

Case 4. Excretory urogram. The left kidney is nonfunctioning and is not visible. A large mass fills the left abdomen. Several irregular translucent streaks are present to the left of the fourth and fifth lumbar vertebrae. The oval shaped translucency just above these is air in the gut. Many irregular calcium deposits are present in the mid portion of the tumor. The intestines are displaced to the right.

At operation, a large fatty tumor was found and removed. The left kidney was firmly attached to the mass and had to be extirpated. The spleen was inadvertently lacerated during the surgical procedure and, because of this, had to be removed.

Grossly the tumor was of fatty consistency. The pathologist observed that sections of the specimen diminished considerably in size when exposed to fat solvents.

Microscopically, there was adult fat present, but frequent mitotic figures were also noted. Several calcium deposits, measuring from one to two cm. in diameter were found within the tumor.

The final diagnosis was liposarcoma of the retroperitoneal space.*

Case Report 5

Mr. O. B. K. was a 68 year old white male newspaper man whose chief complaint was that of progressive excruciating pain in the right thigh of about two months duration. The family physician had noted progressive enlargement of the liver over a three month period.

The patient had had some previous hospital admissions, with diagnoses of chronic alcoholism, food poisoning, arteriosclerotic heart disease, auricular fibrillation and generalized arteriosclerosis. A right lumbar sympathectomy had been done.

Physical examination revealed a well developed and nourished male in acute discomfort. The liver border could be felt a few centimeters below the costal margin. The abdomen was soft and nontender. The right leg seemed slightly cooler than the left, but the femoral and dorsalis pedis pulses in both legs were of good quality.

Roentgenographic examination about two months prior to the present admission had shown a questionable enlargement of the liver shadow (Figure 5A). However, a similar film two months later, during the final admission, showed the presence of a large mass in the right abdomen; it was displacing the abdominal structures to the left and was elevating the right diaphragm. (Figure 5B).

*The authors are indebted to Drs. Leonard Long and Steve Cline of Georgia Baptist Hospital for the use of this case.

The patient's hospital course during this final admission was steadily downhill, and he died.

Post mortem examination was done. On opening the abdomen, a very large retroperitoneal tumor was seen. This filled the entire right side and extended across the mid line to the left. The tumor was multilobular. There was forward and downward displacement of the liver and invasion on its posterior side; the tumor and the liver were so adherent that they could not be separated. There was also extension of the tumor into the adrenals, pancreas, right psoas muscle and mesentery. Distant metastases were found in the lungs and bone marrow.

The combined weight of the tumor and liver was 5.5 kilograms. On cut surface, the greater portion of the tumor was yellowish-brown in color, and had a soft, necrotic consistency. Many of the smaller nodules were greyish-yellow and firm.

Microscopically, the tumor proved to be a mixed type of liposarcoma. The preponderant picture was that of closely packed sheets of cells containing ovoid or round vesicular nuclei having a polyhedral shape; the cytoplasm varied from cell to cell, some being coarsely granular and eosinophilic, others being clear vacuoles. With special staining, these vacuoles prove to contain fat.

The final diagnosis was retroperitoneal liposarcoma, with extensive metastases.

Discussion

The five cases presented here demonstrate that abnormal fat deposits in the retroperitoneal space can be identified on the roentgenograms in some instances. In cases 1 and 3, the translucent areas were quite striking, but in these cases there were areas within the tumor which were not of a translucent nature; the combination of these two factors made the diagnosis of liposarcoma almost a certainty. In

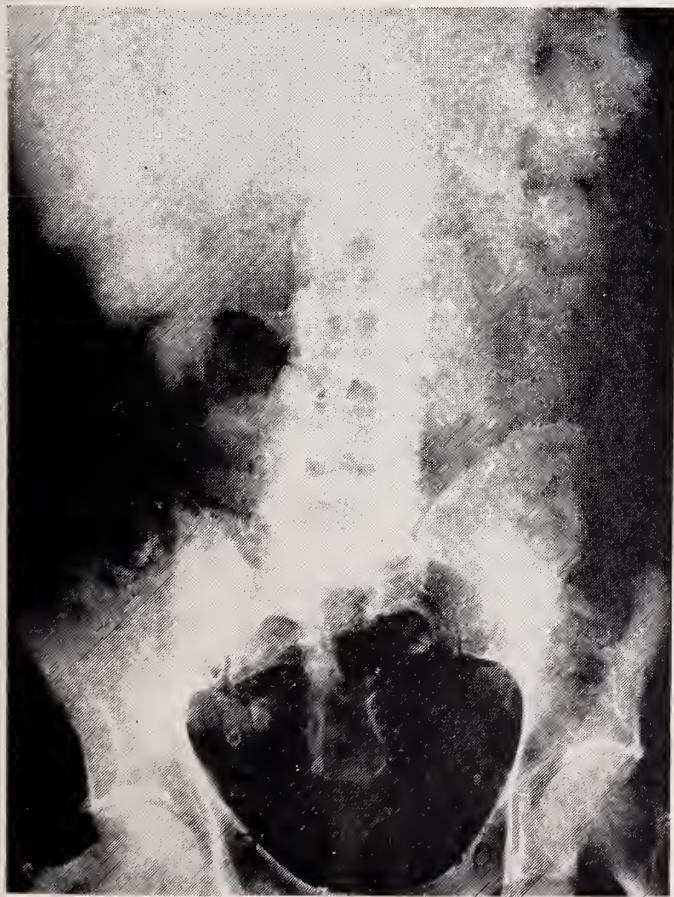


FIGURE 5A

Case 5. Initial film of the abdomen, showing a questionable enlargement of the liver shadow. The right psoas muscle shadow is not visible; this could be the result of the liposarcoma or of the previous right lumbar sympathectomy (metallic clips).



FIGURE 5B

An abdominal film two months later. A very large mass fills the right abdomen, and extends across to the left side. The intestines are all displaced to the left. The film density is too light for any estimation of fat content within the tumor.

case 2, there were vague translucencies visible in the left upper quadrant, but a mass could not be outlined; this case suggested the diagnosis of a tumor of fatty origin, but liposarcoma could not have been diagnosed. In case 4, a mass was visible, and several translucent streaks could be seen; this was interesting in view of the fact that the microscopic examination showed fairly extensive fat deposits. In case 5, the initial film made several months before death revealed only a questionable enlargement of the liver shadow, but the final film showed a very large mass filling the entire right abdomen and extending into the left side. This final film was of such poor technical quality that translucent areas could not be evaluated; it is doubtful that any would have been seen even on a good film because of the embryonic nature of the tumor shown by microscopic examination.

Thus, two of the five cases were diagnosable as liposarcomas from roentgenographic findings alone.

The roentgenograms in case 3, the patient with recurrence, illustrated the changing pattern of the tumor; in his earlier films, considerable adult fat was present in the tumor and was visible roentgenographically. But with recurrence the percentage of fat was greatly reduced, and the film correspondingly showed less translucent areas.

The roentgenogram in case 4 showed relatively few translucent areas even though the tumor was fairly extensive in size and in fat content. The probable cause for this phenomenon is that the translucency of fat is a relative value and not absolute; in an obese individual where considerable normal fat is present and where the abdomen is thick, the density created by these normal structures may obscure that of the translucent tumor, whereas in a thin individual with little abdominal fat the relative densities may be quite different.

Marked displacement of the kidney or obliteration of its normal shadow commonly occurs, and it was present in four of the five cases. Liposarcomas usually arise near a kidney and grow to large size, and for these reasons kidney displacements are

greater in degree in the presence of liposarcoma than with most other retroperitoneal tumors.

In the evaluation of translucencies in tumors, one must keep several other factors in mind:

(1) Ordinary retroperitoneal fat in an obese individual may be fairly extensive. This fat, however, is uniformly distributed in the usual areas for such deposits, and it does not present the picture of mass formation or irregularity seen with liposarcomas.

(2) Air shadows in the stomach and intestines may closely resemble the translucencies of fat, and differentiation may not be possible on routine abdominal films. In such events, further localization of the stomach and gut can be made by upper and lower gastro-intestinal studies.

(3) Poor processing of the film, particularly over-exposure and undevelopment, may produce translucent streaks on the films simulating the irregular streaks seen in some liposarcomas. Inspection of the entire film for other areas of streaking should make a differential diagnosis possible.

Summary

Retroperitoneal masses containing both fatty and non-fatty elements should warrant a presumptive diagnosis of liposarcoma. In two of the five cases presented in this communication, these findings were present, and the diagnosis was made from roentgenographic findings alone.

Emory University Hospital

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Atrio-ventricular Septal Perforation Following Myocardial Infarction

L. R. WHATLEY, M.D., and W. HARVEY HOWELL, M.D., Cartersville, Ga.

PERFORATION OF THE interventricular septum following myocardial infarction was first described by Latham¹ in 1845. Evidentially, however, the medical profession remained generally unaware of this complication, for in 1942, nearly one hundred years later, Weber² was able to find only 33 recorded cases. In recent years clinicians have become increasingly aware of this phenomenon, and many more cases have been reported. While still not common, the condition is no longer considered a rarity, and its ante-mortem diagnosis is being made more frequently. A survey of the literature in 1952 by Zucker et al³ revealed 75 recorded cases, 28 of which were diagnosed during life. To these they added two cases of their own.

In all these 77 cases the perforations have involved the interventricular septum, usually near its apical portion. The following is a case report of an instance of atrio-ventricular septal perforation following myocardial infarction. As far as we have been able to find this is the first such case recorded.

Case Report

The patient was a 77 year old white male admitted to the hospital on the night of December 21st, 1953, with moderately severe substernal pain radiating to the jaw and down both arms.

His past history was significant only in that one year previously he had had a one week episode of semi-coma, restlessness and mental confusion, thought to be on a cerebro-vascular basis. He was treated at home for this with parenteral fluids, and he recovered. Following this he was able to engage in part-time work until the present illness.

On admission the patient appeared to be in moderate pain, but his color was good. His blood pressure was 155/110, pulse 70 and regular. The heart sounds were of good volume and no murmurs were present. The lungs were clear. His pain was relieved with morphine, and he spent a comfortable night.

The following morning his blood pressure was noted to have dropped to 120/90 but his general condition remained excellent. Laboratory work at this time showed a white count of 14,900 and a

sed rate of 48mm/hr. Urinalysis revealed a specific gravity of 1.025 with 2+ albuminuria but otherwise negative. EKG revealed depression of the ST segment in leads one, AVL and V1-V6, and elevation of the ST segment in leads three and AVF. A diagnosis of posterior myocardial infarction was made.

For two days the patient's general and cardiac status remained good with the blood pressure ranging around 120/90. On the third day however he began to exhibit restlessness and mental confusion, and his intake and output dropped. He remained thusly for the next three days; at times he had to be forcefully restrained, and once, while unattended, he got out of bed altogether. His intake was supplemented with parenteral fluids, and by the end of the fifth day there seemed to be some improvement in his mental state. His cardiac status continued to remain stable and generally good.

The following morning the patient again complained of substernal pain and was found to be pale and clammy with a barely perceptible pulse beating at a rate of 60 per minute. The blood pressure was 80/70. The heart sounds were distant and muffled and a soft, low-pitched, grade two (0-6, Levine) systolic murmur was heard over the entire precordium. This murmur had not been heard previously. There was no thrill, and the lungs remained clear. There was only slight distention of the neck veins. Perforation of the interventricular septum was thought to be the most likely possibility.

Despite the administration of neo-synephrine and 500 cc. of dextran, the blood pressure gradually fell and became unobtainable. The heart beat remained slow but the sounds became more distant. The patient lapsed into coma and expired quietly 20 hours later.

Postmortem examination: On opening the chest, the pleural cavities were each noted to contain about 300 cc. of straw-colored fluid. The lungs were heavy and showed moderate edema on cut surface. The pericardial cavity contained about 20 cc. of bloody fluid. The heart was moderately enlarged with hypertrophy of the left ventricle. An extensive infarct involved the upper two-thirds of the posterior

aspect of the left ventricle, sparing only the apical portion. The infarct was also found to involve the right fibrous trigone, the lowest portion of the inter-atrial septum and a large part of the upper portion of the interventricular septum. A slit-like opening, measuring nearly two cm. in width, was found to connect the cavities of the left ventricle and the right atrium. This opening began just medial to the medial commissure of the mitral valve, extended through the right fibrous trigone and emerged into the right atrium about one centimeter above and parallel to the medial cusp of the tricuspid valve.

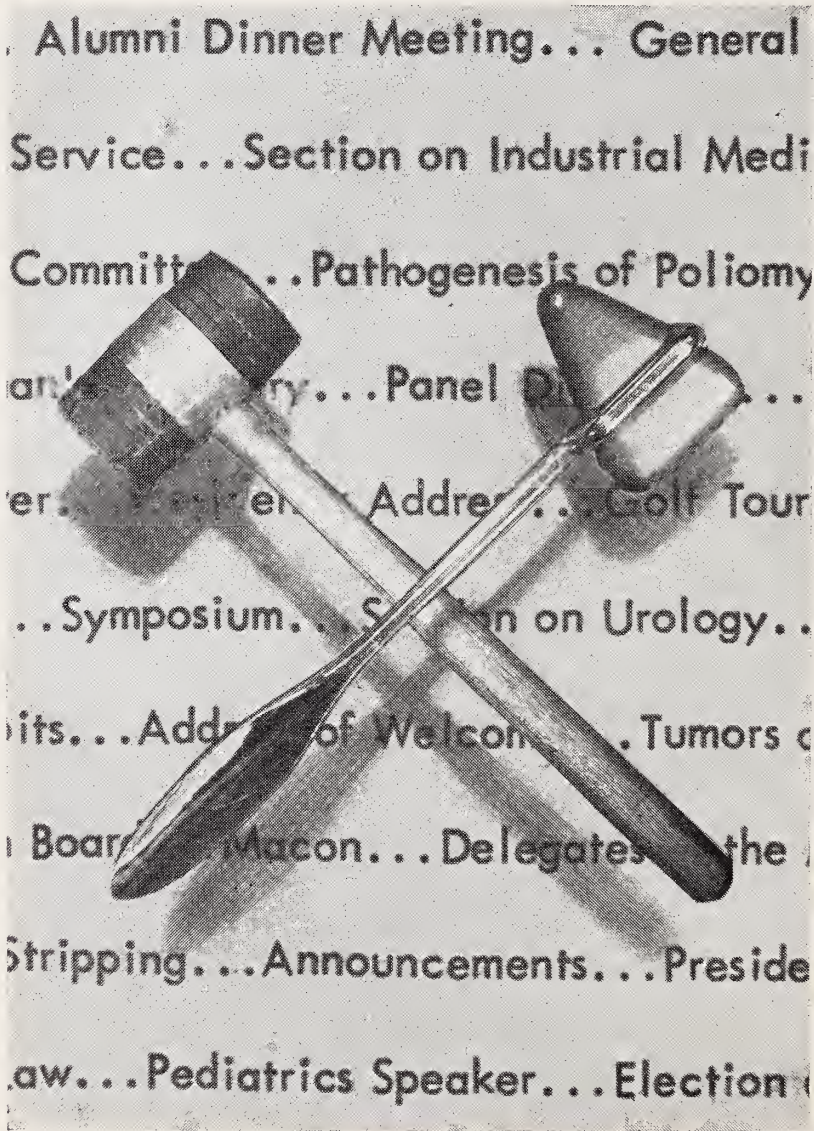
The tissues around this channel were hemorrhagic and infarcted.

The remaining viscera were essentially normal.
Howell-Quillian Hospital

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AVAILABLE PHYSICIANS

Berry, Bradley, D., M.D., Whitfield, Mississippi—Age 35; married; Methodist; graduate Jefferson Medical College, Philadelphia, Pennsylvania, 1953; completed internship; interested in general practice in Georgia in community under 10,000; available one month after notified.

Brooking, Donald W. G., M.D., 228 Finley Drive, Decatur, Alabama—Age 33; married; Protestant; graduate University of Minnesota, 1948; residency Brooke Army Hospital and Cornell University Medical College; passed examinations for certification by American Board of Dermatology and Syphilology; interested in dermatology in a clinic, as assistant or associate or industrial; available immediately.

Bryant, Milton F., Jr., M.D., 8166 USA Hospital, APO 547, San Francisco, California—Age 29; married; Protestant; graduate University of Michigan, 1948; residency University of Michigan Hospital; certified by American Board of Surgery; in service at present; specialty general surgery; available August 1955.

Clark, James H., M.D., Butler, Alabama—Age 32; married; Baptist; graduate University of Tennessee, 1946; recently in practice; desires location with better hospital facilities; interested in general practice.

Collins, Douglas, M.D., 172 Riverside Park, Iowa City, Iowa—Age 33; married; Methodist; graduate University of Alabama School of Medicine, 1951; residency State University of Iowa Hospital; specialty Ob-Gyn; available July 1, 1955.

German, Walter A., Jr., M.D., 1934 Shoup Court, Apt. 2, Decatur, Georgia—Age 30; married; Methodist; graduate Washington University School of Medicine, 1951; residency Grady Memorial Hospital; specialty ob-gyn; desires associateship; available July 1, 1955.

Gorman, John B., M.D., Capt. USAF (MC) AME, 6110th USAF Hospital, APO 1054, San Francisco, California—Particularly interested in general practice with some surgery or possible industrial medicine; graduate University of Virginia, 1951; rotating internship Charity Hospital 1951-52; practiced in Arizona less than a year before entering Air Force; licensed to practice in Virginia; served during past year as chief of Otolaryngology, and Chief of Aviation Medicine at General Hospital, Nagoya, Japan.

Hanberry, Richard L., Jr., M.D., 177 First Avenue, S. E., Atlanta, Georgia—Age 32; married; Episcopalian; graduate Medical College of Georgia, 1951; residency Grady Memorial Hospital, Atlanta; specialty Ob-Gyn; available August 1, 1955.

Hunter, I. H., M.D., 204 East Hill Avenue, Valdosta, Georgia—Age 73; married; Missionary Baptist; graduate Trant University, Chattanooga, Tennessee, 1903; interested in general practice; specialty pediatrics; prefers community of 1,000; will accept good position with clinic; been in active practice for 50 years.

Jerius, Dlab H., M.D., 18218 Appline Street, Detroit, Michigan—Age 51; single;

Protestant; graduate Lausanne University; Switzerland, 1935; residency Sinai Hospital, Detroit; interested in general practice in Georgia as an associate; available immediately.

MacKavanaugh, James L., M.D., 160 Marion Avenue, Merrick, L. I., New York—Age 45; married; Roman Catholic; graduate Georgetown University Medical School, 1934; presently in general practice; wishes to relocate; Priority III; interested in general practice in Georgia, size not too important; available within two to three months after location is selected.

McConnell, Ben H., M.D., Box 664, Beltsville, Maryland—Age 36; married; Episcopal; graduate Georgetown University, 1950; interested in general practice as student health physician with any school, college or university; available at once.

Marder, Leon, M.D., 323 East Chestnut Street, Louisville 2, Kentucky—Age 32; married; Hebrew; graduate University of Oklahoma, 1949; USAF reserve; residency St. Johns General and Michael Reese Hospitals; specialty internal medicine; wishes to associate or share office space with another physician or enter private practice in a community where vacancies exist; available July 1, 1955.

Matousek, Wm. Chas., M.D., 9766 TU, Camp Detrick, Maryland—Age 31; married; Protestant; graduate University of Illinois, 1948; residency Walter Reed Army Hospital; passed Part I of the American Board of Internal Medicine; take Part II in May; available July 1955.

Mohr, Alzon J., M.D., Tremonton, Utah—Age 40; desires rural area where one may raise a family in pleasant surroundings; preferably near a hospital; served in Army during World War II; been practicing in Utah since 1945; graduate Northwestern University; 10 years as a general practitioner; available immediately.

Patterson, James L., M.D., 412 National Bank Building, Logan, West Virginia—Age 55; married; Presbyterian; graduate Medical College of Virginia, 1928; residency C & O Hospital, Huntington, West Virginia; presently in practice, would like climatic change; interested in industrial medicine in Georgia.

Peake, Charles O., M.D., 884½ 9th Avenue S.E., Rochester, Minnesota—Age 27; married; graduate University of Pennsylvania 1951; internship Evanston Hospital; residency Mayo Foundation; Priority IV; specialty ob-gyn; prefers community of 50,000 or over; interested in locating in Georgia, particularly Atlanta, in clinic, as assistant or associate; available July 1, 1955.

Richardson, B. A., M.D., 544 West 2nd Street, Lexington, Kentucky—Age 28; married; Methodist; graduate University of Tennessee, 1954; interested in general practice in Georgia; available August 1, 1955.

Scruggs, W. H., M.D., Bryson City, North Carolina—Age 65; limited general practice; licensed in Georgia; married; Baptist; graduate University of Maryland, 1913; prefers small town with hospital; available anytime during next three months.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland—Age 30; married; Roman Catholic; graduate Georgetown University 1948; residency USN Hospital, Bethesda, Maryland; Priority IV; specialty internal medicine; prefers community in Georgia of 20,000 to 30,000; available June 1955.

Shannon, Lloyd W., M.D., 1234 Henleaze Avenue, Moose Jaw, Saskatchewan, Canada—Age 31; married; Presbyterian; graduate University of Manitoba, 1947; presently in practice, wishes to relocate because medicine is becoming greatly socialized in Saskatchewan; specialty general surgery; industrial assistant or associate, would consider clinic; available February or March 1955.

Sharp, Thomas B., Jr., M.D., 1530 Shoup Court, Decatur, Georgia—Age 28; married; Protestant; graduate Emory University, 1950; residency Lawson VA Hospital; Grady Memorial Hospital; military requirements fulfilled; specialty internal medicine; clinic preferred; available July 1, 1955.

Watson, Alfred Lawrence, M.D., 1415 Titus Road, Memphis 11, Tennessee—Age 29; married; Methodist; graduate Vanderbilt University School of Medicine, 1949; residency Grady Hospital and Kennedy VA Hospital, Tennessee; Priority IV; specialty internal medicine; available July 1, 1955.

Wimberly, John A., M.D., 909 North Broadway, Lexington, Kentucky—Age 29; married; Methodist; graduate University of Louisville, 1952; residency St. Joseph Hospital; will finish one year general surgery July 1, 1955; Priority IV; available July 1, 1955.

AVAILABLE LOCATIONS

Arlington, Georgia (Calhoun County)—Population 1,382. In need of doctor-surgeon for practice in new excellently equipped 16-bed hospital, located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia.

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Bremen, Georgia (Haralson County)—Population 3,500. Need an associate in field of obstetrics and gynecology. Completing a modern office building to house the group and new 20 bed hospital is in operation. Group consists of three physicians—two in surgery and one in medicine and anesthesia. Would have all the work he could handle. Contact Dr. J. H. Pritchett, Jr., Bremen, Georgia.

Dillard, Georgia (Rabun County)—Population 2,500. Doctor's office to be furnished rent free for one year; would rent five or six room house, fully equipped kitchen, county hospital at Clayton; drug store and pharmacist; good schools; doctor would be welcome right now; late doctor had an excellent practice; other benefits considered in a short time; active church groups and community club that would be happy to assist doctor. Contact: Mrs. L. Neville, Dillard, Georgia.

Edison, Georgia (Calhoun County) — Population 1,245. Two physicians in area; Hill-Burton Hospital (1 mi.); one clinic local with 10 beds, x-ray, lab equipment, operating room with instruments; rental \$75.00 (maximum \$100.00) per month; two excellent drug stores; housing available for rent at \$30-\$40; good elementary and high schools; five churches; great need for a physician in this community. Contact: Dr. J. S. Beard, Edison, Georgia.

Marietta, Georgia (Cobb County) — Population 10,000. Interested in Negro physician to replace present physician who is going into Armed Forces in approximately six months. Contact: Mr. M. L. Wear, Administrator, Kennestone Hospital, Marietta, Georgia.

Roswell, Georgia (Fulton County) — Population 2,500. Two physicians in area, ages 73 to 40; hospital facilities in Atlanta; nice office space available rent free; housing can be arranged; very good opportunity for physician who wants plenty of practice; one of the physicians has been out sick for about two months; section is growing rapidly. Contact: Roswell Lions Club, Roswell, Georgia.

Winder, Georgia (Barrow County) — Population 6,000. Eight physicians in area; four active, two part time and two inactive; 40 bed Hill-Burton Hospital in city limits — completely equipped; office space available; three active drug stores; interested in obtaining services of two or

three young physicians who want to do general practice; feel that area has much to offer with a good sound economy, ideal location, adequate hospital facilities and a crying need for well trained interested men; contact, by phone, mail or in person for any further information, Dr. C. B. Skelton, Peoples Bank Bldg., Winder. (Office Phone 3851).

Woodbine, Georgia (Camden County) — Population 1,000. Small, fully equipped office and clinic available; ample office space, delivery room, laboratory (inc. x-ray), nursery, wards, private rooms; five room wooden dwelling adjoins hospital available at \$35.00 mo.; one other doctor in Woodbine, doctor is needed now. Contact: Dr. S. C. Atkinson, Waverley, Ga.

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abstracts by georgia authors

Raiford, Morgan B., Ponce de Leon Infirmary, Atlanta, Ga. "Perimeter with Controlled illumination and Recording Mechanism," Arch. Ophthalm. 52:550-556 (October) 1954.

A perimeter with recording mechanism was designed in order to obtain precise fields of vision and exclude extraneous apparatus from view of the patient. In order to detect early pathological changes induced by glaucoma, retinal disease and abnormal findings affecting the intracranial portion of the visual pathway, even lighting upon the test object is necessary. Equal illumination, silent action of target motion and extraneous distracting mechanisms are eliminated. The perimeter is of sturdy, lightweight construction made out of plastic tubular steel. The dome is of black, non-gloss, plastic finish having an inside radius of 50 centimeters. The perimeter base rests on a tripod and can be rotated at 15° intervals throughout a complete circle. Illumination is made by two small reflectors which are controlled by rheostats going from 1/10 to 15 foot candles illumination. The recording mechanism is in a complete housing, dustproof and silent. A 1:30 ratio of recording mechanism has been used in order to accurately outline the field of vision. Fields of vision were taken from 22 eyes from 11 patients and compared with other type perimeters. Examinations of patients with glaucoma, optic nerve pathology and macular pathology revealed a greater accuracy of visual field detail.

Advantages of design are:

1. Controlled illumination.
2. Standard control of test object movement enabling the examiner to present to the patient a steady, continuous and accurate movement of the target.
3. More accurate isolation of areas of scotomata, both relative and absolute.
4. More accurate recognition of early causes of conditions causing enlargement of the blind spot.
5. Elimination of extraneous distractions, allowing more accurate fields of vision and better patient cooperation.
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King, James T., Medical Arts Bldg., Atlanta. "Senile Tonsillar Gigantism," Sou. Med. J. 47:1155-1156 (Dec) 1954.

Reported is a case of massive hypertrophy of the tonsils in a 68 year old Negro man wherein swallowing and breathing were dangerously obstructed. Only two other similar cases have been reported in the English and American literature.

The patient was first seen in November 1949 in the Grady Hospital OPD. The complaint was difficulty in breathing and swallowing which had begun one year previously. The tonsils were greatly enlarged. In addition he was found to have tertiary syphilis and arteriosclerotic heart disease. Antiluetic therapy was not beneficial; so tonsillectomy was attempted. He collapsed during the induction of the anesthetic and surgery was postponed. Over the next 18 months his symptoms became progressively worse despite various treatments. He lost 79 lbs. and became too weak to walk. Breathing became so labored that he had to sit up and pull to get his breath. The pharynx was found to be almost entirely obstructed with gigantic tonsillar masses.

In January 1952 tonsillectomy was performed without difficulty under combined local and pentothal anesthesia. Pathological examination found no evidence of tumor. Twenty-one months later his general health was still poor, but the condition for which he was operated on (difficulty in breathing and swallowing) remained corrected.

Martin, J. D., Jr., and McGarity, William C., Emory University Hospital, Emory University, Ga. "A Clinical and Experimental Evaluation of the Noble Procedure," Sou. Med. J. 47:1180-1184 (Dec) 1954.

Most surgeons have experienced the difficulty of treating patients disabled by recurring adhesions following peritonitis. The problem becomes increasingly great with each successive episode of partial or complete obstruction, for in time the abdominal organs may become involved in a veritable mass of adhesions.

T. B. Noble first reported the use of plication of the small intestine as a prophylactic measure against the formation of adhesions. His original experiences primarily related to the use of plication for peritonitis from various sources. Later, as more

experience was obtained, the same procedure was recommended by Noble and others for chronic intestinal obstruction from recurring adhesions.

Three clinical cases are presented which exemplify the numerous preoperative complications and the hazards following the procedure. Following these experiences and due to lack of knowledge of the end results of the plicated intestines, these experiments were performed.

In a series of dogs plications of the intestines were done and observations were made for changes in electrolytes and nutrition. In a follow-up of the experiments by reoperation or autopsy, the fixations by plications were not found to be totally satisfactory. This was due to the breakdown of suture line which left openings through which intestinal loops could be caught and also permitted the formation of new less desirable adhesions.

It is felt that some cases may be benefited by the Noble procedure. Indiscriminate performance is to be avoided. Satisfactory solution has yet to be devised for the problem of postoperative, recurrent intestinal obstruction.

Logue, Bruce and Hurst, J. Willis, Emory University School of Medicine, Emory University, Ga. "Errors in the Recognition and Treatment of Heart Disease," Circ. 10:920-932 (Dec) 1954.

Some of the common errors in the diagnosis and treatment of heart disease are discussed. The use and abuse of digitalis, pitfalls in the differential diagnosis of chest pain, the mistakes common in the diagnosis and management of heart failure are brought out. The problems related to intractable congestive heart failure and the limitations of electrocardiography in the recognition of coronary disease are discussed.

Norris, Jack C. and Armstrong, W. B., 478 Peachtree St., N. E., Atlanta. "Membranous Cryptococcic Nasopharyngitis (Cryptococcus Neoformans)," Arch. Otolaryng. 60:720-722 (Dec) 1954.

The malady is also known as Torulosis or European Blastomycosis and as Busse-Buschke disease. The cryptococci produces pulmonary infection, deep seated abscesses, skin lesions of a nodular type and, most often in Southern countries, is the cause of a low grade fatal subacute meningitis.

In the case presented by Norris and Armstrong, the patient was a woman of mid age, who had a "runny nose" after taking a cold. She expelled much jelly-like mucous, slightly blood tinged, from her nasal passages. The throat became involved, with a low fever and pain. A similar membrane like the nasal one, appeared in the upper nasopharyngeal and uvula areas, which was tenacious and plastered-on in character. Cultures and smears were positive for spherical coccoid bodies of a single budding type. The patient had a slight leukocytosis of 9,800 with 10 per cent eosinophiles.

Treatment of this condition was difficult because neither of the observers had seen this disease before, therefore it was largely symptomatic, experimental and routine. Gentian violet, two per cent solution, alternating with hexylresorcinol, was cautiously applied to the throat and nasal areas daily. Potassium Iodid was given orally, and the throat was gargled freely with hot saline solution. After about a week's time the throat membrane began to recede and finally disappeared, leaving a violaceous edematous base. She has apparently remained well but will be kept under observation. This patient was of particular interest, not only because of the rarity of the condition, but because she had never been to any place where such a malady might have been contacted.

Chambers, William R., 101 Third St., N. E., Atlanta, Ga. "Acute Occlusion of the Internal Carotid Artery," Surg. (Jan) 1954.

Acute spontaneous occlusion of the internal carotid artery may simulate stroke, multiple sclerosis, brain tumor or other diseases of the brain. It is being found with increasing frequency by the use of carotid angiography. The most common site is just distal to the bifurcation of the common carotid, but occlusion at the siphon is also frequent. Therapy is in the formative stage. However, early diagnosis together with arterectomy and anticoagulant therapy offer hope of benefit.

Five cases are presented, the youngest, 11 years; the oldest, 48. Cases in the literature range from seven years to 78. Some the artery.

Dobes, William L., 478 Peachtree St., N. E., Atlanta, Ga. "The Role of Histopathology in Modern Dermatological Practice", *Sou. Med. J.* 48:21-27 (Jan) 1955.

Much progress in dermatology has been made in the past few years both in clinical diagnosis and pathological interpretation of skin lesions. Dermatohistopathology has become so specialized that as a rule one cannot depend on a general pathologist for proper evaluation and interpretation of certain skin diseases. If a general pathologist intends to interpret skin biopsies he should have special training in dermatopathology, and, if possible, some background in clinical dermatology. Serial sections are often important and will occasionally uncover findings that the single or sparse sections fail to do. Nine cases of questionable clinical diagnosis with a definite histopathological picture were presented.

Dow, Philip, Medical College of Georgia, Augusta, Ga. "Dimensional Relationships in Dye-Dilution Curves from Humans and Dogs, with an Empirical Formula for Certain Troublesome Curves", *J. App. Physiol.* 7:399-408 (Jan) 1955.

Graphical, numerical, and statistical analyses were applied to several series of the arterial concentration curves resulting from rapid intravenous injection of T-1824 or Brilliant Vital Red for determination of cardiac output and central blood volume. Forty-six curves were from human subjects gotten by successive arterial sampling; 213 curves were obtained from dogs by direct densitometry of transiently exteriorized blood.

The time from injection to peak of the curve averaged 1.60 times the appearance time in the human series, 1.70 in one dog series, 1.54 in another. Corresponding ratios of mean transit time to appearance time were 1.97, 2.19, and 1.75. Central blood volumes calculated from downslopes of the curves averaged 0.3 of the volumes calculated from the mean transit times.

When one semilog decade of downslope takes more than three appearance times, or when the recirculatory break on the downslope occurs at more than $\frac{1}{2}$ the peak concentration, a rough empirical formula is advocated as preferable to the conventional semilog extrapolation for curve area. This estimate of the area is the function of $PC \times PCT / (3.0 - 0.9 PC/AT)$, where PC is peak concentration, PCT the time from injection to peak, and AT the appearance time.

Ginder, David R., Emory University School of Medicine, Atlanta, Ga. "Resistance to Fibroma Virus Infection, The Role of Immune Leukocytes and Immune Macrophages", *J. Exper. Med.* 101:43-58 (Jan) 1955.

Fibroma virus, injected intracutaneously in domestic rabbits, produces localized tumors composed of fibroblasts. Neutralization of fibroma virus can be easily demonstrated by injecting virus-immune serum mixtures into susceptible rabbits and comparing the size of the resulting fibromas with fibromas resulting from injection of fibroma virus-normal serum mixtures. Using this host-virus system, it was demonstrated that the addition of living leukocytes and macrophages, obtained from fibroma-immune rabbits, significantly increased the neutralization of fibroma virus as compared with the effect of immune serum alone. The fibroma virus neutralizing ability of specific immune cells appears to be related to small undetected amounts of intra-

cellularly placed antibody or to formation of specific antibody by the cells following their injection into the rabbits employed in the neutralization test.

King, James T., 384 Peachtree St., N. E., Atlanta, Ga. "Effects of Vitamin K Compound (Synkayvite®) on Computed Blood Loss During Adenotonsillectomy", *Ann. Oto. Rhino. & Laryng.* 63:1029-1030 (Dec) 1954.

The object was to evaluate the effect of Synkayvite® on the amount of blood lost during adenotonsillectomy. Comparison of blood loss was made between two groups of patients undergoing this operation; one group received this vitamin prior to the operation and the other did not. A simple method of computing blood loss during surgery was described.

Reported were 176 children, upon whom adenotonsillectomy was performed and in whom the blood loss was computed. To each of 85 cases five mgm. of Synkayvite was administered orally three times daily for one week preceding the operation. The remaining group of 91 cases did not receive this medication. The same operative technique was used in all cases and all medication and preparation were the same in both groups.

In the first group (85 cases receiving Synkayvite) the maximum blood loss in a single case was 150 cc. and the minimum was 20 cc. The average blood loss in this group was 53 cc. In the second group (91 cases not receiving Synkayvite) the maximum blood loss was 165 cc., and the minimum was 14 cc. The average blood loss in this group was 51 cc.

Synkayvite had no significant effect on the amount of blood lost.

Lewis, John R., Jr., 478 Peachtree St., N. E., Atlanta, Ga. "The Management of Facial Scars", *J. Internat. Coll. of Surgeons* 23: 78-92 (Jan.) 1955.

Facial scars are caused by:

- (1) Infection (acne, chicken pox, small pox, lupus, cellulitis)
- (2) Trauma (automobile accidents, injuries, burns)
- (3) Congenital defects (hairlip scars)
- (4) X-ray irradiation
- (5) Surgical trauma (cautery, surgery)

The psychological aspects of facial scars should not be underestimated by the family doctor or by the surgeon. Scars are a common cause of inferiority complex, leading to inadequate social, marital and business adjustments.

The correction of facial scars consists of surgical excision and repair of individual scars, or of surgical abrasion of pock marks, or uneven scars. Surgical excision and abrasion may be combined to give even better results in some cases. Traumatic scars and acne scars may be corrected under local anesthesia in adults, and often by a combination of rectal surital and local anesthesia in children.

The pre-operative and post-operative care and the surgical techniques are described for the various types of scars and the different locations about the face. Keloids may be treated more successfully by the use of hyaluronidase injections, surgical excision and follow-up x-ray irradiation as a combined treatment.

Photographs illustrate the various types of scars and the results of surgery.

\$100,000 Grant to Emory

A GRANT OF \$100,000 FROM the John A. Hartford Foundation, Inc. will make possible the continuation and development of research in burns and blood diseases now in progress at Emory University hospital.

The grant, announced by Ralph W. Burger, president of the foundation, will be used over a two-year period. The foundation was established by the late John A. Hartford, who, for many years before his

death in 1951, served as president of The Great Atlantic and Pacific Tea Company. This is the foundation's first grant to Emory.

Dr. Charles M. Huguley, Jr., assistant professor of medicine in the Emory University School of Medicine, will direct the investigations in three blood diseases, and Dr. J. D. Martin, Jr., clinical professor of surgery, will direct research in treatment of thermal burns.

ANNOUNCEMENTS

American Goiter Association Meeting—April 28, 29 and 30, 1955, Skirvin Hotel, Oklahoma City, Okla. For information write Dr. John C. McClintock, Secretary, American Goiter Association, 149½ Washington Ave., Albany, N. Y.

Georgia Heart Association Annual Award—\$100 will be awarded to intern, house officer or fellow in Georgia Hospital, or physician in Georgia who has practiced five years or less for best paper presented to the Association on any subject in the field of cardiovascular diseases. For information contact the Georgia Heart Association, 318 Western Union Bldg., Atlanta 3, Ga.

Short Course in the Clinical Pathology and Pathology of Parasitic Diseases—August 15-17, 1955, Louisiana State University School of Medicine, New Orleans, La. The fee for the course is \$50.00. For further information write to Dr. Clyde Swartzwelder, Dept. of Microbiology, L. S. U. School of Medicine, 1542 Tulane Ave., New Orleans 12, La.

American Congress of Physical Medicine and Rehabilitation Annual Essay Award—The contest is open to anyone; the winner shall receive a cash award of \$200, a gold medal, certificate of award and an invitation to present the paper at the 33rd Annual Session of the American Congress of Physical Medicine and Rehabilitation (see below). All inquiries should be addressed to the American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Ill.

American Congress of Physical Medicine and Rehabilitation 33rd Annual Session—August 28-September 2, 1955, Hotel Statler, Detroit, Michigan. Open to all members of the A. M. A. For full information write to Dorothea C. Augustin, 30 North Michigan Avenue, Chicago 2, Illinois.

American College of Surgeons Sectional Meeting—April 4-6, 1955, Nashville, Tennessee. For further information write to the American College of Surgeons, 40 East Erie Street, Chicago 11, Ill.

International College of Surgeons Scholarship—\$3,000 scholarship to be awarded to American or Canadian Surgeon for study abroad. Recipient will be expected to spend at least 10 months of the year as a resident or fellow in a teaching center in one of the countries of Europe or South America. For details, address The Scholarship Committee, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

American Society of Plastic and Reconstructive Surgery 1955 Scholarship Contest—Deadline for all entries is July 1, 1955. For further information write to the Award Committee, c/o The Foundation of the American Society of Plastic and Reconstructive Surgery, Inc., 30 Central Park South, New York 19, N. Y.

Recent Advances in the Study of Venereal Diseases 7th Annual Symposium—April 28 and 29, 1955, Department of Health, Education and Welfare, Washington, D. C.

Emory Postgraduate Medical Clinics—March 31, 1955, Woodruff Memorial Building, Emory University and April 1, 1955, Grady Memorial Hospital, Atlanta. Registration fee for the clinics will be \$5.00. For further information, contact the Alumni Office, Emory University, Emory University, Ga.

Fourth Annual Symposium for General Practitioners on Tuberculosis and other Chronic Pulmonary Diseases—July 11 to 15, 1955, Saranac Lake, New York. It is approved for 26 hours of formal credit for members of the A. A. G. P. Sessions will be held in various sanatoria, hospitals and laboratories in the Saranac Lake area; many will be informal panel discussions with ample opportunity for questions from the audience. Registration fee is \$40.00. For further information write to Dr. Richard P. Bellaire, General Chairman, Symposium for General Practitioners, P. O. Box 2, Saranac Lake, N. Y.

South Atlantic Association of Obstetricians and Gynecologists—New officers for 1955 are as follows: president, Waverly R. Payne, Newport News, Va.; vice-president, Charles J. Collins, Orlando, Fla.; president-elect, John C. Burwell, Jr., Greensboro, N. C.; secretary-treasurer, C. Hampton Mauzy, Winston-Salem, N. C.; and assistant secretary-treasurer, W. Norman Thornton, Charlottesville, Va.

South Carolina Heart Association Sixth Annual Meeting—April 11 and 12, 1955, Baruch Auditorium, Medical College of South Carolina, Charleston, S. C. The business session will take place April 11; the scientific session will be on the 12th. All Georgia physicians are invited to attend. For information write to the Medical College of S. C., Charleston, S. C.

Student American Medical Association Fifth Annual Convention—May 6, 7 and 8, 1955, Sherman Hotel, Chicago, Ill. Highlights of the meeting include an address by Dr. You Chan Yang, Korean ambassador to the U. S.—“Medicine and Diplomacy”—and panel discussion in which Louis J. Ragan, M.D., physician-lawyer will take part on forensic medicine.

American Trudeau Society 50th Anniversary Meeting—May 23-27, 1955, Milwaukee Auditorium, Milwaukee, Wis.

Dr. Louis N. Katz, Chief of Cardiovascular Research at the Michael Reese Hospital, Chicago, will speak at Grady Hospital Junior Lecture Room, Wednesday March 30th at 12:30 p. m. This lectureship is sponsored by the Beta Nu Chapter of the Phi Delta Epsilon Fraternity, Emory University School of Medicine. The subject of Dr. Katz' lecture will be, “Hormonal Control of Atherosclerosis”. All MAG members are cordially invited to attend.

American College of Physicians Course on “Stress and Aging”—April 21-24, 1955, Lankenau Hospital, Philadelphia, Pa. For further information write to Dr. Edward L. Bortz, 2021 West Girard Ave., Philadelphia.

1955 Industrial Health Conference—April 23 to 29, 1955, Memorial Auditorium, Buffalo, New York. Industrial physicians, hygienists, nurses and dentists from all over the country will gather to discuss the progress of industrial health.

DEATHS

JOHN F. DENTON, 77, Atlanta, died January 30, 1955, in a private hospital. He was born in Dalton and received his education at the Webb School and Emory University. Dr. Denton attended the New York University Medical School and did postgraduate work at Bellevue Hospital and in the New York City Health department.

In 1906 he returned to Atlanta to practice. During his 48 years' practice he was visiting gynecologist to Grady Hospital, Steiner Clinic and Emory University. He was for many years professor of clinical gynecology at Emory University Medical School.

Dr. Denton was a member of the board of trustees of the Georgia Division of the American Cancer Society and a Life Member of the Fulton County Medical Society. He was also a member of the American College of Surgeons, Southern Surgical Society, the Southeastern Obstetrical and Gynecological Society. He belonged to the First Presbyterian Church, Sigma Alpha Epsilon and Phi Alpha Sigma fraternities.

Funeral services were held on January 31, 1955, at Spring Hill with burial in Westview Cemetery, Atlanta.

O. O. FANNING, Atlanta, died on February 26, 1955, after an illness of several years. He was 81 years old.

A native of Springfield, S. C., Dr. Fanning attended old Emory at Oxford. He was graduated in 1908 from the Atlanta School of Medicine. He was superintendent of Wesley Memorial Hospital, now Emory Hospital, in 1908 and 1909. In 1909 he became superintendent of the Fulton County Almshouse where he remained for one year. Dr. Fanning served in the Army Medical Corps in World War I.

Dr. Fanning entered the private practice of medicine in 1910 and continued until his retirement in 1950. He was a Life Member of the Fulton County Medical Society, a Methodist and a Mason.

Funeral services were held on February 28 with burial in Westview Cemetery.

J. E. FLOWERS, Doraville, died February 17, 1955, at the age of 88.

Dr. Flowers was a graduate of the University of Georgia and received his M.D. degree from Emory University School of Medicine in 1890. He practiced in Doraville for more than 60 years, remaining active until three years ago.

He took an active part in civic affairs; a member of the DeKalb County Board of Health for more than 25 years, he also served several terms as a member of the Doraville City Council. Dr. Flowers gave part of the land for the development of Flowers Park in Doraville.

Dr. Flowers was a member of the Prospect Methodist Church in Chamblee.

SOCIETIES

NINTH DISTRICT MEDICAL SOCIETY will hold its spring meeting on April 20, 1955, as guests of the Stephens County Medical Society. Program includes a report of the activities of the Subcommittee on Maternal and Infant Welfare in the Ninth District by J. L. Walker, Clarksville; a paper on "Pyloric Stenosis" by P. K.

Dixon, Jr., Gainesville; a paper—"The Treatment of Chest Injuries"—by Rudolf J. Noer, Professor of Surgery at the University of Louisville; Clinical Pathological Conference presented by Dr. Hamil Murray, with discussion by Samuel D. Hay, Toccoa.

THE TENTH DISTRICT MEDICAL SOCIETY met February 17th in Augusta. A golf tournament was held in the morning and then ward rounds were made with Robert Major (surgery), V. P. Sydenstricker (medicine) and the pediatric staff. Scientific sessions were held in the afternoon and evening. Papers presented were as follows: V. P. Sydenstricker, Augusta, "Use and Abuse" of Cortisone"; Thomas P. Findley, Jr., Augusta, "Diabetes Mellitus"; Robert B. Greenblatt, Augusta, "Indications for the Use of Estrogens and Androgens in the Female". Allen J. Flemming, Medical Director of the du Pont Company, moderated the scientific program in the evening; George H. Gehrmann, Associate Medical Director of du Pont, spoke on "The Progress in Industrial Medicine for the Past 40 Years"; John H. Foulger, Director of Medical Research for the du Pont Company, spoke on "The Problem of Chemical Poisoning in the Home"; and Gerald Gordon, Associate Psychiatrist of du Pont, spoke on "The Family Physician's Role in Industrial Psychiatry". Physicians and their wives had dinner at the Old Medical College Building on Telfair Street, Augusta.

BIBB COUNTY MEDICAL SOCIETY members have presented a series of medical forums in Forsyth. Subjects for these discussions were "Diseases of Childhood", "Heart Disease and High Blood Pressure" and "Psychosomatic Medicine". Panel members for the last mentioned were Walter Bramblett, Jr., Forsyth, moderator, Darrell Hazelhurst, Shannon Mayes and T. M. Hall, all of Macon.

Macon's second annual series of medical forums was begun on March 15. Sponsored jointly by the Bibb County Medical Society and the *Macon Telegraph and News*, the topics and dates are as follows: March 15—"Allergies", March 22—"The Handicapped Child", March 29—"Nervousness" and April 4—"Cancer". Moderators for these panel discussions are Frank Houser, Tom Ross, E. C. McMillan, Jr., and Jap Hogan. Speakers, in order of their appearance, are Darrell Hazelhurst, Charles Rumble, Nicholas P. Dallis (creator of the comic strip "Rex Morgan, M.D.") and Tom Harrold.

The GEORGIA MEDICAL SOCIETY has presented medical forums in Savannah for the second year. The topics discussed were "Nervous Tension" (March 1), "Hereditary and Contagious Diseases" (March 15), "Overweight and Underweight" (March 22) and "Growing Old Gracefully" (March 29). Moderator for the panel on "Nervous Tension" was Peter L. Scardino; speaker, Jacob Rubin; and panel members were John E. Porter, Alton F. Williams, E. N. Gleaton and A. H. Center. The second forum had Joseph Pacifici, Harry E. Rollings, J. L. Alexander and W. U. Clary on the panel. The third forum, on "Overweight and Underweight", was moderated by T. A. Peterson, and W. O. Bedingfield was the speaker. The subjects were chosen by the public who signified their choice on ballots which were published in the Savannah newspapers. Peter L. Scardino is chairman of the forum committee, J. C. Metts

is vice-chairman, and members are W. Osler Beddingfield, Thomas A. McGoldrick, Jules Victor, Jr., and Irving Victor.

THE CHEROKEE-PICKENS MEDICAL SOCIETY held its January meeting on the 28th of the month in Jasper. A dinner for society and auxiliary members preceded the meeting. All the officers for 1954 were reelected to serve in 1955. They are Ben K. Looper, Canton, president; A. M. Hendrix, Canton, vice-president; and C. J. Roper, Jasper, delegate.

For the second straight year, the COBB COUNTY MEDICAL SOCIETY and the *Marietta Daily Journal* have sponsored a series of medical forums in Marietta. The first forum on March 3rd, had as its subject "Cancer"; panel members were Henry Meaders, M. N. McCall, Warren Mathis, Charles Henderson, Ralph Fowler and Ruth McClure. The second forum on March 17th, dealt with "High Blood Pressure", and the panel was composed of the following physicians: Jack Hodges, Charles Jennings, W. C. Mitchell, Jack Kaley, George Cauble and J. Pattillo.

GORDON COUNTY MEDICAL SOCIETY has elected Charles Richards, Calhoun, president of the Society for 1955. Other officers elected were William Purcell, Calhoun, vice-president; and J. LeRoy Rabb, Calhoun, secretary.

The regular meeting of the HABERSHAM COUNTY MEDICAL SOCIETY was held at the Commercial Hotel, Cornelia, following a dutch treat dinner with the Auxiliary on February 3, 1955, at 7:30 p. m. Herbert Alden, Atlanta, presented a paper on "The Care of the Skin in the Aged".

THE JACKSON-BARROW MEDICAL SOCIETY met at the Winder-Barrow Hospital in Winder on January 31. Members had dinner in the hospital dining room before the meeting. J. Ken Adams, Jefferson, reported on four cases of psittacosis which were encountered in Jefferson recently.

At a recent meeting of the LAURENS COUNTY MEDICAL SOCIETY held in Dublin, the speakers were M. Bedford Davis, Atlanta, and C. C. Aven, Atlanta. Dr. Aven discussed the development of diagnosis and treatment of tuberculosis, and Dr. Davis discussed surgical aspects involved. Officers elected at this meeting were John A. Bell, Jr., Dublin, president, and James F. O'Daniel, Macon, secretary-treasurer.

THE MUSCOGEE COUNTY MEDICAL SOCIETY and the Columbus Ledger-Enquirer sponsored a series of five medical forums in Columbus the first of which was February 17, 1955. The subject for the first forum was "Cancer"; J. A. Elkins was moderator, A. B. Conger, speaker; and the following physicians were panel members: George L. Epps, George M. Hutto, Col. Robert Rhea, W. F. Jenkins, Robert H. Vaughan and W. S. Clifford. The second panel discussion was held on February 24, the subject was "Old Age". Luther H. Wolff was moderator. The third—"Heart Attacks"—was moderated by Norman S. Luton. The fourth—"Children's Diseases"—was moderated by Hugh J. Bick-erstaff. The fifth and last was on "Nervousness", and the moderator was George R. Conner. Franklin Ed-

wards, chairman, George M. Hutto and A. J. Kravtin compose the forum committee.

Charles Mulherin, Augusta, Chairman of the RICHMOND COUNTY MEDICAL SOCIETY Public Relations Committee, has announced that the society and *The Augusta Chronicle* will sponsor three medical forums this year. The dates are March 27, April 24 and May 8. All three will be held in the Bell Auditorium.

RANDOLPH-TERRELL MEDICAL SOCIETY officers for 1955 are as follows: F. E. Sims, Dawson, president; F. S. Rogers, Coleman, vice-president; and Robert D. Martin, III, Cuthbert, secretary and treasurer. A. R. Sims, Richland, was elected to the Board of Censors; other members are Walter D. Martin, Dawson, and F. S. Rogers, Coleman.

THE SOUTHWEST GEORGIA MEDICAL SOCIETY held its first bi-monthly meeting of the year in Colquitt. The society adopted a new constitution and by-laws at this meeting. C. D. Hollis, Albany, addressed the meeting on "The Newer Developments in the Diagnosis and Treatment of Rheumatic Heart Disease".

THE WALKER-CATOOSA-DADE MEDICAL SOCIETY met at the Chattanooga Golf and Country Club on January 25th. Dennis M. Cornett of LaFayette was host for the occasion. After dinner Walter E. Boehm addressed the society on the use of hypothermia in surgery. Officers for 1955 are LeBron Alexander, Rossville, president; Robert L. Patterson, Chattanooga, Tenn., vice-president; E. M. Townsend, Ringgold, secretary-treasurer; and Fred Simonton, Chickamauga, and Roy Pope, Jr., Chickamauga, delegates to the Medical Association of Georgia.

W. J. Gower, Thomaston, has been elected president of the UPSON COUNTY MEDICAL SOCIETY for 1955. Other officers recently elected are W. P. Woodhall, Thomaston, vice-president; and H. D. Tyler, Thomaston, secretary-treasurer.

PERSONALS

The following physicians were recently appointed by Governor Marvin Griffin to serve on State Boards:

Named to the Board of Social Security were MARCUS MASHBURN, SR., Cumming, and E. M. LANCASTER, of Shady Dale.

HUGH HAILEY and A. A. RAYLE, Atlanta, were both reappointed to the Medical Board of the Workmen's Compensation Board.

H. C. DERRICK, Lafayette, was named to the Hospital Advisory Committee, and H. L. DISMUKE, Ocilla, was named to the Medical Board of the Social Security Board.

J. W. PALMER, Ailey, R. H. McDONALD, Newnan, L. W. WILLIS, Bainbridge, and ALEX B. RUSSELL, Winder were appointed to the State Board of Medical Examiners. Dr. Willis was appointed for the first time while the others were reappointed.

First District

MARVIN ENGEL, Darien, attended the Mid-South Post Graduate Meeting in Memphis, Tenn., February 7 through 11. Mrs. Engel accompanied Dr. Engel on this trip to Memphis.

L. M. FREEDMAN and MICHAEL J. EGAN, Savannah, are co-chairmen of the Doctors' Committee of St. Joseph's Hospital Building Campaign. They will solicit pledges from medical staff members of St. Joseph's and the medical profession throughout Savannah. The goal of the campaign is \$850,000.

ANNE MCHENRY HOPKINS, Savannah, was elected president of the Chatham-Savannah Health Council at a meeting held January 31. Other physicians elected to serve with her were LAWRENCE LEE, president-elect, and ISOM WALKER, ELLISON R. COOK, III, R. B. GOTTSCHALK and RUSKIN KING, trustees. A panel discussion of the problem of the chronically ill was held at this meeting. THOMAS A. MCGOLDRICK, Savannah, was a panel member, and JOHN H. VENABLE, Atlanta, was moderator.

JULIUS T. JOHNSON, Midville, spoke at a recent meeting of the Midville Parent-Teacher Association; the topic of his address was "The Salk Polio Vaccine", and he discussed the records of preventives since 1916.

HENRY LEVINGTON, Savannah, has been honored by having his name inscribed in Hadassah's Medical Center which is now under construction in Israel. Children brought into the world by Dr. Levington accorded him the honor. FRANK HOFFMAN, Savannah, the first baby delivered by Dr. Levington, presented the certificate to him.

A. G. PINKSTON, JR., Glennville, announces the opening of his new clinic in Glennville. Open house was held at the clinic on January 23. The building is constructed of concrete block and brick veneer and is modern throughout. It has facilities for white and colored patients, including treatment and examining rooms, laboratory, x-ray and dark rooms, and a delivery and surgery suite. Dr. Pinkston graduated from the Medical College of Georgia and interned for one year at the University Hospital. After three years service in the U. S. Army, Dr. Pinkston came to Glennville, where he has been in private practice for the last eight years.

A memorial marker honoring Crawford W. Long, for whom Long County was named, has been placed in the court house square of Ludowici. The marker was unveiled on Tuesday, February 22; Judge Robert H. Humphrey, of the Middle Georgia Judicial Circuit, was the guest speaker, and music was by the Jesup High School Band.

Second District

J. T. ARLINE, Cairo, recently observed his 89th birthday. Dr. Arline is a Life Member of the MAG and has been retired for several years.

E. L. EVANS, Tifton, has been named the "Outstanding Kiwanian" by the Tifton Kiwanis Club by virtue of his "loyalty and service to the local Kiwanis Club and to Kiwanis International". Dr. Evans was a charter member of the Tifton club, is a past president and has had perfect attendance for 14 years.

Third District

E. V. MILLER, Columbus, has been named Columbus' Negro "1954 Man of the Year" by the Young Men's Progressive Club. Dr. Miller was educated at Dillard University, Atlanta University and Meharry Medical College.

KENNETH MUNN, Columbus, spoke to the Brotherhood of the First Baptist Church in Manchester on January 17. He pointed out to the men how tobacco and alcohol are destructive to the human body.

Fourth District

Benjamin L. Camp, Franklin, has recently gone into practice of medicine and surgery with G. B. FISHER at the Heard County Memorial Hospital. Dr. Camp is a native of Whitesburg; he graduated from Northwestern University Medical School in 1933 and served as District Medical Officer with the Civil Conservation Corps in Illinois and Wisconsin until 1940, when he entered private practice in Ellijay. He served in the Army Medical Corps from 1941 through 1948. From then until October 1954 he practiced in Rome, Italy. While in Italy, he received a diploma in medicine and surgery from the University of Modena.

WILLIAM B. FACKLER, JR., J. W. CHAMBERS and CURRAN S. EASLEY, JR., LaGrange, formed a panel to discuss the heart drive and heart disease at one of the February, Heart Month, meetings of the Optimist Club in LaGrange.

MORGAN KELLUM, Thomaston, has been elected a Qualified Fellow in the International College of Surgeons; which rank will be conferred in Philadelphia in September 1955.

HART ODOM, who has been associated with Gilbert's Clinic in Greenville for sometime, has opened his office in Woodbury where he will practice privately.

Dr. and Mrs. T. A. SAPPINGTON and Dr. and Mrs. J. A. WOODALL, Thomaston, entertained the local doctors and their wives at a buffet dinner on February 10 at the home of the Sappingtons. Mrs. Justus Gower won the cake which was given away as a door prize. Dr. and Mrs. GEORGE BROWN, Griffin, and Dr. and Mrs. GEORGE ALEXANDER, Forsyth, also attended.

Fifth District

The Veterans Administration Army-Navy Conference on the Chemotherapy of Tuberculosis was held at the Academy of Medicine, February 7 through 10. Doctors from 50 VA hospitals were joined in the conference by professors from leading medical centers where anti-tuberculosis research is in progress, and by tuberculosis specialists from the Army and Navy. A powerful new drug, Cycloserine®, which has removed all apparent traces of tuberculosis bacilli in a number of test patients was disclosed to the physicians attending. Also discussed at this meeting were the effects of surgery in tuberculosis and the advisability of using hormones routinely in treating certain cases of tuberculosis meningitis.

The joint meeting of the Southeastern Surgical Congress and the Atlanta Graduate Assembly was held at the Biltmore Hotel, Atlanta, February 21 through 24, 1955. The Southeastern Surgical Congress celebrated the 25th anniversary of its original meeting. Speaking on the same topics covered in the first meeting, they reviewed progress made in the intervening years. Among the guest speakers were, George Crile, Jr., Cleveland; J. Montgomery Deaver, Philadelphia; Waltman Walters, Minneapolis; and Hubert A. Royster, Raleigh, N. C. Dr. Royster spoke at the first meeting. Addressing the

Atlanta Graduate Medical Assembly were Reed Nesbit, of the University of Michigan; William B. Terhune, New York psychiatrist; Burgess Gordon, President of the Woman's Medical College of Philadelphia; Robert W. Wilkins, Boston; Elmer C. Bartels, of the Lahey Clinic, Boston; and Duncan M. Reid, professor of obstetrics at Harvard Medical School. Addressing joint meetings were Herman L. Blumgart, professor of medicine at Harvard Medical School; George Pack, head of the Pack Medical Group of New York City; and William Dameshek, of the New England Center Hospital.

JANET ALEXANDER, Decatur, was the speaker at a recent meeting of the Women of the Church of the First Presbyterian Church of Marietta. Her topic was "Christianity in India". Dr. Alexander served for 32 years in India and Pakistan as surgeon-in-charge and general director of the Nancy Fulworth Hospital in Montgomery, India. She was awarded the Kaiser-i-Hind medal for public service from the British government.

SAMUEL A. ANDERSON, Atlanta, announces the removal of his office on March 1, 1955, to Suite 222, W. W. Orr Doctors Building, 478 Peachtree St., N. E., for the practice of psychiatry. Dr. Anderson's new telephone number is Cypress 5330.

CARL C. AVEN, Atlanta, recently celebrated his 68th birthday anniversary, and many of his friends, patients and associates gave him a surprise party at the Academy of Medicine in Atlanta. They gave him a leather bound portfolio of letters of appreciation, and his first patient, his first secretary, his former nurse, a medical school teacher and many others were on hand to salute him. The party was the climax of a Community Chest Council Health Section meeting which Dr. Aven attended as he usually does. Mr. Don Elliott, president of the Atlanta Tuberculosis Association, presided at a localized version of "This Is Your Life".

L. MINOR BLACKFORD, Atlanta, is chairman of the new medical and nursing subcommittee on disaster, organized by the Atlanta Red Cross. Serving on the volunteer committee are CHARLES HOLLOWAY, WADLEY GLENN, R. H. SMOOT, W. S. DOROUGH, DUNCAN SHEPARD, WILLIAM MITCHELL, PAT SHEA, IRA FERGUSON, J. W. VEATCH and JOHN W. TURNER.

T. STERLING CLAIBORNE, Atlanta, spoke to the members of the Monroe Lions Club at a recent meeting. The topic was "Diseases of the Heart", and he stressed the importance of supporting the Georgia Heart Association and the fund raising drive that was held in February.

JOHN THOMAS GODWIN, Atlanta, a native Georgian and graduate of Emory University School of Medicine, is the first full time pathologist at St. Joseph's Infirmary, and he is also director of the laboratories at the hospital. Dr. Godwin came to Atlanta from New York where he was assistant attending pathologist at Memorial Hospital for cancer and allied diseases, assistant visiting pathologist for the James Ewing Hospital and abstract editor for *Cancer*, the journal of the American Cancer Society. He was senior scientist and head of the pathology division of the Atomic Energy Commission's Brookhaven National Laboratory, at Upton, Long Island.

LON GROVE, Atlanta, announces his retirement from

the active practice of surgery.

LESTER RUMBLE, JR., Atlanta, spoke at the February meeting of the Woman's Auxiliary to the DeKalb County Medical Society. The topic of his talk was "Medical Forums".

HARRY PARKS, Atlanta, announces the removal of his office to the Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree St., N. E., Atlanta.

JOE S. ROBINSON, Atlanta, announces the opening of his office for the practice of surgery, 710 Peachtree Street, N. E.

There's somebody new at the home of Dr. and Mrs. F. R. SANDERS, JR., Decatur—it's a baby boy born February 17, 1955, and named Floyd Stuart Sanders. Stuart weighed in at seven pounds 14½ ounces and should soon be a match for his four year old sister Irene.

Sixth District

E. M. LANCASTER, Shady Dale, is the physician to ask about answering services—he has installed an automatic telephone answering device which answers the phone and records messages. Since Dr. Lancaster keeps office hours in Shady Dale in the morning and in Monticello in the afternoon, this device is probably kept busy.

F. O. PEARSON, Macon, Medical Commissioner of the Central Health Region of the State Health Department, was the guest speaker at the February meeting of the Monroe County Health Council.

EDGAR R. PUND, Augusta, was the guest speaker at a recent luncheon meeting of the Milledgeville Rotary Club. Dr. Pund discussed the expansion of the Medical College and its relationship to the new Eugene Talmadge Memorial Hospital.

Dr. and Mrs. WILLIAM RAWLINGS, Sandersville, announce the birth of a son, Joseph Benjamin, on February 8, 1955, at Rawlings Sanitarium.

WILBUR M. SCOTT, Milledgeville, has been appointed to the Board of Trustees of the Georgia Military College.

Seventh District

C. H. ALLEN, Bremen, attended a course in surgery of trauma and vascular surgery in the Tulane University Division of Graduate Medicine in New Orleans in January.

RAYMOND F. CORPE, Rome, is presenting a paper—"Bronchography Immediately Following Bronchoscopy"—with Eugene S. Hwa, also of Rome, at the 50th Anniversary Meeting of the American Trudeau Society in Milwaukee, Wisconsin, May 23-27, 1955.

CHARLES M. GARLAND, Smyrna, has gone to Erlanger Hospital in Chattanooga, Tenn., for a year in residence to study gynecology and obstetrics.

SARA ORTON, Rome, of the Battey State Hospital staff, was elected president of the Pilot Club of Rome at the February meeting of the club. She will be installed in April and assume her new duties in May.

Eighth District

W. L. POMEROY, Waycross, has been named chairman of the Ware County Hospital Board.

Ninth District

EDWIN H. ETHERIDGE, Winder, has reported for active duty as a Lieutenant, Medical Corps, with the U. S. Navy. Richard F. Graves, now serving his internship at St. Mary's Hospital in Athens, will occupy Dr. Etheridge's offices after July 1st.

Attending the meeting of the Board of Directors of Physicians Services, Inc., Columbus, were PAUL T. SCOGGINS, Commerce, EUGENE L. WARD, Gainesville, A. G. SINGER, Toccoa, and GEORGE T. NICHOLSON, Cornelia.

CHARLES B. TEAL, JR., formerly of Cedartown, has announced the removal of his office to the Cole Building in Ellijay. Born at Fitzgerald, Dr. Teal graduated from the University of Georgia and the Medical School of Syracuse University. He interned at Grace Hospital, Detroit, and was at Russell Hospital in Alexander City, Ala., for two years before going to Cedartown.

Tenth District

Dr. and Mrs. W. W. BATTEY, Augusta, spent the month of January on a South American Cruise, and from all reports it must have been a very exciting trip. They stopped in 11 ports, and Dr. Battey attended a meeting of the American College of Surgeons in Lima, Peru.

Dr. and Mrs. STEWART DIXON BROWN, JR., Royston, announce the birth of a son, Robert Moore, on January 18, 1955, at Athens General Hospital.

STEPHEN W. BROWN, Augusta, has been named a director of the First National Bank and Trust Company of Augusta.

H. L. CHEVES, Union Point, has been elected 1955 president of the Union Point Chamber of Commerce.

A \$6,268 grant for heart research has been made by the Georgia Heart Association to the Medical College of Georgia bringing to \$30,248 the total awarded to the College since July 1st. This latest grant is to provide personnel, equipment and supplies for the Georgia Heart Laboratory of Cardiovascular Research under the direction of THOMAS FINDLEY.

CHARLES MULHERIN, Augusta, presented a paper at the recent meeting of the South Atlantic Association of Obstetricians and Gynecologists. Mrs. Mulherin accompanied him on this trip to Williamsburg, Va.

JOHN H. SHERMAN, Augusta, is the new president of the staff of St. Joseph's Hospital; C. G. HENRY is vice-president; and CHARLES G. LUTHER, secretary-treasurer.

News from the Southern Medical Association

Under the Chairmanship of Dr. Denton Kerr, the Houston, Texas, meeting of the Southern Medical, Nov. 14-17, 1955, is shaping up splendidly. Numerous committees have been appointed, and are at work. A large "Kick-off dinner" was held March 19, and more than 200 Houston physicians are taking part in an effort to make the meeting the largest and most interesting one ever held in Texas. Reservations should be made now.

State Membership Promotional Committees have been organized, and six states members have been selected. Georgia's group are: Drs. Kirk Train, Savannah; Sydenstricker, Augusta; Phillips, Macon; Cason, Warrenton; Harbin, Rome; and Norris of Atlanta. The ultimate goal is to secure Southern Membership for every qualifying Georgia physician.

One thousand lineal feet of exhibit space has been obtained at the Shamrock Hotel, and Mr. V. O. Foster, the Secretary-Treasurer, and Mr. Butts are now ready to receive application for scientific exhibition.

Crawford W. Long Rides Again

THE INAUGURATION OF Governor Marvin Griffin was the first in the history of the State of Georgia to be celebrated by the staging of a parade. One of the floats in this parade (see cut) symbolized another first that occurred in our State . . . the discovery of the anesthetic powers of ether by Dr. C. W. Long of Jefferson, Georgia. The float was sponsored by the citizens of Jefferson and the surrounding area which constitutes the Tenth Congressional District. Dr. Lester Rumble, Jr. acted as technical advisor for the Shepard Decorating Company who prepared the float. The surgical equipment was provided through the courtesy of the A. S. Aloe Company's Atlanta office. The "characters" were portrayed by some of the leading citizens of Jefferson.



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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1955 by the Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; 1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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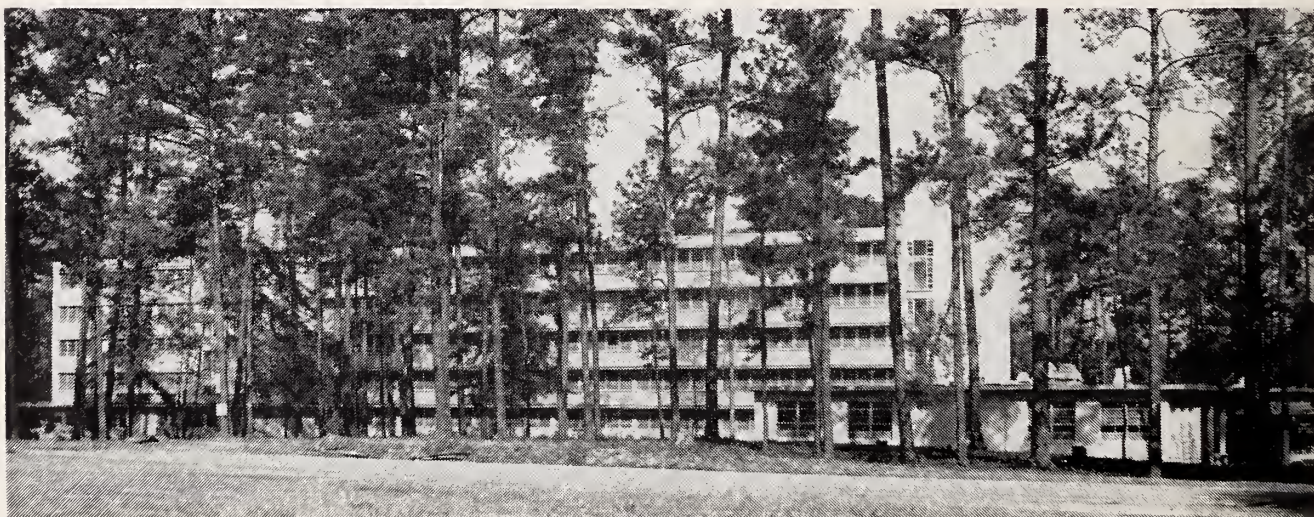
The photography minded physician might be interested in how the cover picture was taken. It was made on a fast Panchromatic film using 1/10 of a second at f.4.5. The 4x5 Crown Graphic camera was mounted on a tripod. Photo by Ted F. Leigh, M.D.



BREMEN GENERAL HOSPITAL
Bremen, Georgia

The Bremen General Hospital was opened for the reception of patients on December 20, 1954. This hospital has a capacity of 25 beds. A pri-

vate hospital with 15 beds was closed with the opening of the new hospital.



PINEVIEW GENERAL HOSPITAL
Valdosta, Georgia

The Pineview General Hospital, Valdosta, was opened for the reception of patients in January 1955. This new well-equipped hospital has a capacity of 100 beds. With the opening of a new

hospital a private hospital of 80 beds was closed. Local, state and federal funds in the amount of \$1,580,000 were expended in the construction and equipping of this hospital.



CANCER OPERATION TELECAST FROM ATLANTA

ON MONDAY EVENING, March 28, television viewers of Georgia had the opportunity of seeing medicine in action. They were taken into the operating room of an Atlanta hospital to witness a lobectomy for lung cancer. The half hour program, which was telecast on WSB-TV, Atlanta, as a public service was sponsored by the Georgia Division of the American Cancer Society, Fulton County Medical Society, Greater Atlanta's Red Cross Blood Bank, Atlanta Tuberculosis Association and WSB-TV.

Program time was divided between a discussion of the case by Atlanta doctors in a television studio, and the operating room. The patient's story was told using simple terms so that the lay public could understand it well. The close-up scenes in the chest were technically good although occasionally an arm or head obliterated the view. There were appropriate commentaries from the operating room by an announcer and a doctor stationed there. (See page 200.)

Favorable comments have been heard both from the medical profession and the lay public.

This program was designed not as a teaching exercise for physicians, but as a striking reminder to lay persons that something can and is being done about the cancer problem. It was refreshing to see the calm deliberate approach to an operative problem presented rather than the tense operating room scene depicted in most movie productions—that of a patient vacillating between life and death while on the operating table. Only by having some of the fear and superstition removed from the cancer picture can patients be given hope and thus be encouraged to report any suspicious symptoms early.

If there is any single thing that we as physicians are called upon to give our patients more often than any other, it is undoubtedly freedom from fear. Generally patients do not consult us unless they are in pain or are afraid. Usually relief of pain or the treatment of organic disease does not present too much a problem. The treatment of fear of disease for most of us presents a far more subtle and difficult task. Such therapy requires not only knowledge of disease, but the confidence and trust of the patient. Let us not in our zeal for mastery of disease processes, lose sight of those factors around which a satisfactory doctor-patient relationship is built.

WILLIAM STOKES GOLDSMITH 1870-1954

DR. WILLIAM STOKES GOLDSMITH was born in Stone Mountain, Georgia, in 1870. He graduated from Atlanta Medical School, which is now Emory University, in 1892. He was licensed to practice medicine in 1892 and remained in Atlanta until his retirement.

Dr. Goldsmith's early education was obtained at the University of Georgia, before entering medical school in Atlanta.

He was married to Miss Grace Boyd, of Atlanta, in 1897. From this union a son and daughter were born.

Soon after Dr. Goldsmith entered the practice of medicine in Atlanta he became associated as a teacher in the Atlanta Medical College. He was most popular with the students and his lectures were a source of much benefit and enjoyment. He occupied various positions, teaching practically all of the subspecialties of surgery at sometime during his career.

Dr. Goldsmith enjoyed an extensive surgical practice during the many years that he was active. He was a member of the American Surgical Association, a Fellow in the American College of Surgeons and was also a member of the Southern Surgical Association. He was president of the Medical Association of Georgia, 1915-1916. There are few doctors that were so universally respected and held in such high esteem by his colleagues as Dr. Goldsmith.

His contributions to medical literature were voluminous. It may truly be said that Dr. Goldsmith was a general surgeon in every respect, since his bibliography consists of General Surgery, Neurosurgery, Orthopedics and Urology.

He was one of the few who lived to see the tremendous advances in medicine to its present state. He was a pioneer in the development of Atlanta and contributed much towards the early Atlanta history. For many years he was associated with Dr. W. S. Elkin in the operation of the Elkin-Goldsmith Sanitarium.

In Dr. Goldsmith's passing, October 23, 1954, it may truly be said that Atlanta and Fulton County Medical Society, as well as the Medical Association of Georgia, have lost one of the real pioneers. We owe Dr. Goldsmith a very great debt, which we are most grateful to acknowledge.

PROFESSIONAL NEGLECT

DESPITE SOME STATEMENTS to the contrary, American medicine is successful, and with its success the American doctor is successful. Maybe much *too* successful for his own good. William Faulkner, in his acceptance of the National Book Award, suggested that perhaps one of the things wrong with this country is "success." "There is too much success in it. Success is too easy. It can be gained so quickly and easily that the young man has not had time to learn humility, to handle it, or even to discover it, or to realize he will need humility".

Fifty years ago William James also sounded the warning with deep conviction and more direct word, when he wrote to H. G. Wells, "The moral flabbiness born of the exclusive worship of the bitch-goddess Success, that with the squalid cash interpretation put on the word Success, is our national disease."

Such a type of success in the physician can produce a certain amount of intellectual strabismus; a sort of squinting and winking at fact and truth, and thus result in neglect of one's professional responsibilities.

All about us there is a great public hunger for the doctor who will give information on matters of health, about disease and its care and treatment. This public knows of the success of the "wonder

drugs", of the increase in the span of life, of the healthful "American way of living". He asks his physician, "What about it? What is my disease? What is its name? What is it caused by? Will it get well? How is it treated? Will the wonder drugs help? Where can I get information? Where can I get the best treatment? How much will it cost? Is there any research being done on my disease? Do you doctors really know anything about disease?" Anxious people, all wishing answers, help and consolation but above all consideration.

But what do they sometimes get from their busy successful doctor? "I am too busy—I have no time to lecture you on this subject—just do as I tell you—you will be all right!"

There is a great need for the physician, glowing in such scientific success, to take more time to explain these things to his patient. His patient today is more literate, more informed, sometimes half-informed and often intelligent. He wishes explanations not just pills, "shots", diets, operations and short answers. Many ill patients are incredible "worry-warts" and need intelligent information about, and explanation of, their diseases and discomforts. We must give to them.

Let us not be so blinded by success, and so vulnerable to a little praise, that we become victims of professional neglect. Let us give unto others, by thought, word and deed that which we labored so hard to get. In no other way can we so quickly combat the tremendous love for quackery and pseudoscience which our people seem to have.

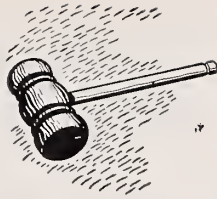
Operation--Health Career Horizons

THE BETTER HEALTH COUNCIL of Georgia is co-operating with a health education program recently announced by the National Health Council. The program is termed Operation—Health Career Horizons and is designed to broaden the high school student's concept of all matters pertaining to health and to increase the recruitment of American youth in the various branches of the health professions so as to provide more fully the health services the people need, demand and are willing to pay for.

In the next two months every high school and junior college in the country will receive one copy of the 160-page *Guidebook—Health Careers*. This is the first publication of the Health Career Horizons

Project of the National Health Council and the first essential step nationally. Next, steps must be taken locally. The Better Health Council will join with local health councils and health divisions, state and national, in an effort to help solve one of the most pressing health problems—the need for sufficient and competent health personnel.

Mrs. Bruce Schaefer, President of the Better Health Council, will participate in the National Health Council in New York. This forum will offer the opportunity to show how health agencies—whether community, state or national can best work together to achieve desired ends.



president's page

Each American physician who is a member of his county or territorial medical society — there are more than 150,000 such physicians — is automatically entitled to join his state's medical association and the American Medical Association. Organized medicine is held together by these associations. We, therefore, should be more aware of what our medical societies and the American Medical Association mean to us individually and collectively. Each county society is represented in the state medical association by its own elected delegates. In turn, the state association elects delegates to the American Medical Association. It is evident that through these channels each duly qualified physician is represented in the American Medical Association, and his voice may be heard if he has anything to say.

The American Medical Association serves not only the physician but the general public as well. While its activities, on the surface, are for the promotion of medical science, its equal aim is for continued improvement of the public's health and protection from injurious foods and drugs. A well equipped laboratory is maintained for these studies. By referring to the American Medical Directory one can immediately learn of the qualifications of any of the more than 150,000 doctors. This directory also gives the desired information about hospitals and their facilities as collected by the Council on Medical Education and Hospitals. The American Medical Association has an office in Washington whereby the interests of organized medicine are carefully and painstakingly protected. Impingements by socialistic trends are recognized and fought in the House and Senate.

The Committee on Legislation of the Medical Association of Georgia was most active during the 1955 Georgia General Assembly which considered 22 bills relating to medicine. Our committee, consisting of Drs. Grady Coker, Chairman, C. C. Aven and J. D. McElroy, with the assistance of Dr. C. L. Ayers and Dr. Marcus Mashburn, did an excellent job for organized medicine.

The county, state and national associations are continuously caring for the welfare of physicians and the public, and we physicians should be well aware of their activities so that we can better appreciate their value and in turn better explain to the public what organized medicine is doing for them.



REVIEWS

Jawetz, Ernest, Ph.D., M.D.; Melnick, Joseph L., Ph.D., and Adelberg, Edward A., Ph.D., *Review of Medical Microbiology*, Lange Medical Publications, Los Altos, Cal., 1954, 360 pages, \$4.50.

There is much of merit in this volume. The authors have displayed great skill and discrimination in blending the basic and the applied phases of medical microbiology with the greatest parsimony of words and yet not at the sacrifice of significant content. The scope of the effort is in part indicated by the fact that this outline fills a volume of some 360 pages and in content encompasses such fundamental aspects as cell structure, bacterial metabolism and variation, as well as applied problems such as specific disease entities. Over one third of the volume is devoted to the rapidly expanding field of virology. If intelligently used by the reader, this volume may prove of great help to the novice and expert alike, and it offers even the practicing physician an opportunity to bring him up to date on changing concepts in microbiology. There are, however, certain limitations inherent in the "outline" approach. Inevitably, the authors often are forced to take an arbitrary, positive stand—as for example, the statement that no immunity is produced in actinomycosis, certainly a field which is still largely unexplored. Again, perhaps inevitable in an outline, outright errors loom larger than they should, such as the statement that staphylocoagulase is non-antigenic. Since the editors plan to re-edit this volume every two years, one may well expect that any mis-statements will be rapidly eliminated. The greatest hazard in the outline approach is that the beginner might use such a volume as a basic text, rather than for review, orientation and crystallization of the material. If properly used, however, the present volume should find well deserved wide favor.

Morris Tager, M.D.

Hussar, Allen, E., M.D., F.A.C.P., and Holley, Howard L., M.D., F.A.C.P., *Antibiotics and Antibiotic Therapy*, The Macmillan Company, New York, 1954, 475 pp., \$6.00.

This book was written to serve as a guide for the clinical use of antibiotic agents. It is divided into three sections. The fundamental aspects of antibiotic therapy including mode of action, microbial sensitivity and resistance, and toxic, allergic and biologic complications of therapy are reviewed in the first section. A general description of antibiotics in clinical use is presented in the second part of the book. The clinically important pharmacology of these agents is presented in concise form. In the third part

antimicrobial therapy of specific bacterial, viral, rickettsial, fungal and parasitic infections is discussed. A final section of this part discusses peculiarities of antibiotic therapy as applied to specialized fields. A selected bibliography follows each chapter.

Certain minor shortcomings are evident. It is unfortunate that the trade names of the "broad spectrum" antibiotics are used throughout instead of the official generic terms. Adequate evidence is not available to warrant the authors' recommendation that chlortetracycline or oxytetracycline be employed prophylactically to prevent secondary infection during epidemics of viral influenza. Whereas the brief period of broad spectrum antibiotic therapy recommended as the treatment of choice for the typhus fevers, Rocky Mountain spotted fever and scrub typhus may be effective in certain instances, more prolonged therapy would seem advisable to insure against relapse. In addition, a general description of certain of the commonly used chemotherapeutic agents other than the antibiotics, such as isonicotinic acid hydrazide, sulfadiazine and sulfisoxazole would have increased the value of the book to the practitioner.

The authors repeatedly and wisely emphasize the serious complications of antibiotic therapy and point out specifically how these agents are so often inappropriately used. The usefulness of some of the less often considered antibiotic agents as bacitracin and polymyxin in controlling resistant infections is discussed. In general the book appears to be a concise, well indexed, readable reference manual, suitable for use by practitioners as a guide to the intelligent use of antimicrobial drugs.

Edward W. Hook, M.D.

BOOKS RECEIVED

Gedda, Luigi, *Genetica Medica*, Edizioni Dell'Istituto Gregorio Mendel, Rome, 1954, 467 pp.

Kahn, Samuel, M.D., Ph.D., *Make Inferiorities Work For You*, Dynamic Psychological Society Press, Ossining, N.Y., 1954, 184 pp.

Maclachlan, John M., Ph.D., *Planning Florida's Health Leadership: Florida's Hospitals and Nurses*, University of Florida Press, Gainesville, 1954, 122 pp., \$1.50.

Ferrer, M. Irene, M.D. (Editor), *Cold Injury* (Third Conference), Josiah Macy, Jr. Foundation, New York, 1955, 226 pp., \$4.50.

The Relation of Hysterectomy for Benign Conditions to Cancer of the Cervix

ENOCH CALLAWAY, M.D., LaGrange, Ga.

THE FACT THAT cancer of the cervix is 10 to 20 times more likely to occur in the cervical stump after a subtotal hysterectomy has been adequately established by numerous investigators. Undoubtedly some of these patients had a cervical cancer at the time of the operation. This condition should always be suspected and proper preoperative procedures carried out to reduce this error to a minimum. In our own studies, aided by a survey made by the Troup County unit of the American Cancer Society, we found there was no appreciable difference in the occurrence of cancer of the cervix in child-bearing and non-childbearing women. Studies made by others have shown a small increase in the disease in women who have borne children. No studies have shown any marked immunity from cancer to exist in nulliparous cervixes. Therefore, the fact that a woman has not had children is no indication to fail to perform a total hysterectomy.

In competent hands there should rarely be any increased risk to the patient in performing a total rather than a subtotal hysterectomy. Since six per cent of patients who die from cancer of the cervix have previously had a subtotal hysterectomy, there can be no doubt that the patient is best served where no portion of the cervix is left.

At the City-County Hospital, LaGrange, Georgia, in 1954, 136 total hysterectomies were performed and only five subtotal hysterectomies. Examination of the patients' charts showed that in only two cases was any reason given why a complete hysterectomy was not performed. From this and from further analysis of our records, it seems reasonable to conclude that a subtotal hysterectomy is indicated in less than two per cent of these patients.

All of the approved hospitals in Georgia and several in Alabama were asked how many total and

how many subtotal hysterectomies were performed in 1954. Seven replied. From these replies the following table was compiled:

<i>All Hysterectomies</i>	<i>Totals</i>	<i>Subtotals</i>	<i>Per cent of Subtotals</i>
37	15	22	59%
106	92	14	13%
149	101	48	32%
462	398	64	14%
361	299	62	17%
376	366	10	2.9%
141	136	5	3.5%
1,632	1,407	225	

If we take three per cent as the highest percentage of cases who should not have had a complete hysterectomy, we see that 176 women have unnecessarily been left to deal with the hazards associated with a cervical stump.

Ignorance, incompetence or indifference apparently are responsible in most instances when a subtotal hysterectomy is performed.

A consultation is required when a hysterectomy is performed on a woman under 50 years old. Would it not be a good idea to have all subtotal hysterectomies reviewed by an appropriate staff committee?

Conclusion: No hysterectomy should be performed without eliminating the presence of cancer. A papanicolaou smear should be considered a minimum preoperative precaution. Biopsies and/or curettement should be done in suspicious cases.

No subtotal hysterectomy should be performed unless some condition exists which would make more complete surgery dangerous to the patient.



Pitfalls of EKG Diagnosis

C. PURCELL ROBERTS, M.D., Atlanta, Ga.

ERRONEOUS interpretation of the electrocardiogram usually results from inadequate clinical study. The test is sensitive and reliable, but it is only one element in the constellation of diagnostic data. Sometimes it is necessary to disregard "abnormal" changes, in the face of reasonable assurances of cardiac integrity; and, again to believe slight and merely suggestive defects, if the patient's findings so justify. To have examinees voice a skeptical attitude toward the EKG is common experience, since many now know that a "normal" tracing alone does not declare a healthy heart. Neither is the graph oracular; unfortunately, it rarely foretells dependably. Serial records are useful, however, to demonstrate the trend of acute or chronic myocardial disease.

As a reflection of bodily homeostasis, the perennial constancy of the well person's EKG is ever impressive. It is the individual's cardiac signature, occasionally showing "defects" which never materialize. Yet, normal designs are seen in decompensated hearts; with minor valvular disease and some congenital anomalies; with early coronary disease—even after the onset of myocardial infarction.

Certain pathognomonic patterns give comforting assurance of the EKG's ready aid,—classical infarction, the several arrhythmias and conduction disturbances, acute and chronic *cor pulmonale*, left ven-

tricular "strain." On the other hand, non-specific alteration of the tracing by various systemic derangements should be anticipated. EKG's in myxedema, tachycardia, anemia, diabetic acidosis, insulin shock and NCA syndrome may simulate those of primary heart disease. Digitalis causes a sagging of ST segments very like that of subendocardial ischemia. Beri-beri changes may mimic those of subacute muscle infarct. ST displacements in acute pericarditis (except for being unidirectional) are exactly as in acute coronary thrombosis. It is true that potential or subcurrent heart disease may be disclosed by functional strain, *e.g.*, if T-wave inversions appear with gall bladder colic, coexistent coronary arteriosclerosis can be presumed.

With added decades of EKG experience, earlier concepts have had to be discarded. Formerly, QRS notching was considered an index of early coronary disease. Now, even bundle-branch block (of the right side) is considered rather innocuous. The prognosis of a coronary patient with defective EKG who has good exercise tolerance is admittedly better than that of the man with normal pattern at rest but suffering new angina of effort. Diagnosis of myocardial disease solely from non-specific pattern aberrations in routine study is to be deplored. Clinical appraisal must continue to vindicate EKG diagnosis.

**Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.**

Physicians Placement Service

TIPS FOR DOCTORS seeking new locations to practice and communities looking for a doctor may be found in two new physicians placement service booklets to be issued late in the spring by AMA's Council on Medical Service. The first, "Physicians Placement Service—1955" deals with the history and present operations of the AMA's placement service, giving special attention to the activities of the services maintained by, or in cooperation with, state medical

societies.

The second booklet answers the question from civic leaders, "What have other communities done to attract physicians?" Brief accounts of modern medical facilities which have been made available to physicians by a number of communities, along with floor plans and photographs, are presented. This pamphlet complements the 1953 booklet, "A Doctor for your Community."

Asymptomatic, Circumscribed (Coin) Lesions of the Lung

OSCAR CREECH, JR., M.D., ROBERT C. OVERTON, JR., M.D., and

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WITHIN THE PAST DECADE increased utilization of chest roentgenograms as a part of routine physical examinations and for mass community surveys for tuberculosis has resulted in the detection of many asymptomatic, circumscribed lung lesions to which the terms "silent" and "coin" have been applied. Although there is variation in the definition of these terms, as used in this report a coin lesion is a circumscribed, roentgenographic density in the chest, surrounded by aerated lung parenchyma and unassociated with symptoms.

For a time these roentgenographic shadows were regarded as residuals of inflammatory disease, and, although bacteriologic confirmation was frequently lacking, the lesions were considered to be tuberculous and were treated conservatively. The necessity for thoracic exploration to establish a correct diagnosis of rounded pulmonary densities was emphasized about 15 years ago by Graham and Singer.¹⁰ Later Alexander² pointed out the malignant nature of many circumscribed lesions within the chest. It was not until 1948, however, when the reports of O'Brien, Tuttle and Ferkenay,¹⁸ and of Effler and associates,⁷ appeared, that the nature of the circumscribed "coin" lesion was fully appreciated. Since then management of these lesions by surgical excision has permitted histologic examination and accurate diagnosis. Thus the relative incidence of the pathologic entities which make up the group of coin lesions is well established.^{5 21 7 15 20}

Pathology

A pulmonary coin lesion may represent one of several conditions:

(1) *Tuberculomas* are the commonest circumscribed pulmonary densities. Formerly these nodules were considered to be healed, relatively innocuous tuberculous foci. Recently^{4 11} it has been demonstrated that they are either walled-off pre-necrotic

tuberculous foci, or filled-in cavities. In either event the contents of the lesions are heavily infected with tubercle bacilli, and breakdown of the tuberculoma is common. (2) *Malignant neoplasms* comprise the second most common type of coin lesion and may be primary or secondary. Of the former, bronchogenic carcinoma is most common, occurring as the squamous cell type in about 50 per cent of cases, as reserve cell or undifferentiated carcinoma in about 30 per cent, and as columnar cell carcinoma in about 20 per cent of cases.¹³ Sarcomas are also encountered as primary lung tumors, usually as fibrosarcomas. Secondary pulmonary neoplasms may have their source in almost any part of the body but are particularly likely to result from hypernephromas, carcinomas of the mammary gland and prostate, and testicular tumors. (3) The commonest *benign neoplasm* presenting as a coin lesion is the hamartoma. Actually this tumor is a tissue malformation rather than a neoplasm. Hamartomas in the lung are composed chiefly of cartilage and have punctate areas of calcification that produce a characteristic roentgenographic appearance.¹⁶ However, it is impossible to definitely establish its identity short of surgical excision and histologic examination. Bronchial adenomas may produce a circumscribed shadow on the roentgenogram, but the diagnosis can generally be established by bronchoscopy since they protrude into the major bronchi.⁸ (4) *Pulmonary coccidioidomycosis* may leave residual nodules in the lungs that are referred to as coccidiomas.³ These lesions are frequently indistinguishable from solitary tuberculous nodules. *Cryptococcosis*, *echinococcic cysts*, *histoplasmosis*, and rarely *vascular tumors* may also present as pulmonary coin lesions.^{14 22 23 9}

Diagnosis

The discovery of a circumscribed pulmonary density in a patient without symptoms calls for certain diagnostic procedures to determine the nature of the lesion.

A carefully taken history may reveal facts that are indicative of the nature of the lung lesion. A personal or familial history of tuberculosis or a history of residency in areas endemic for coccidioidomycosis

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Presented by Dr. Creech at the 104th Annual Session of the Medical Association of Georgia, Macon, May, 1954.

may help to establish the diagnosis of these diseases. The history of a previously treated malignant lesion in another part of the body may lead to a diagnosis of pulmonary metastasis. Although roentgenograms taken earlier are not available for comparison, the patient may have been told of some abnormality by the physician making the examination, and he should be queried regarding this possibility. Generally, physical examination is of little help since the patients are asymptomatic; however, in some instances careful examination may disclose an abnormality that will lead to a correct diagnosis.

As most coin lesions are discovered on routine posterior-anterior films, additional roentgenograms may be helpful in determining more accurately the location, size, shape and borders of the lesion as well as the presence of calcification and lamination. Lateral and oblique views and body section films may be helpful in elucidating these features of coin lesions. In addition, previous roentgenograms should be made available for comparison in order to obtain some idea of the roentgenographic age of the lesion and whether or not a change has occurred. In general, the larger the mass the more likely it is to be a malignant growth. However, all neoplasms must grow from one or a few cells, and, having reached a certain size, may remain dormant for indefinite periods. Thus, in dealing with circumscribed lung lesions, particularly those that are asymptomatic, size alone has little or no significance. Location of the density is rarely of diagnostic importance. Most coin lesions are peripherally placed and occur about equally in each lung, with no lobar predilection. A majority of tuberculomas occur in the upper lobes since they represent reinfection tuberculosis; however, these lesions may be in any part of the lung,

and malignant neoplasms are often located in the apical segments. The borders of the roentgenographic density may be smooth or lobulated, well demarcated or indistinct. In general, bronchogenic carcinoma has less well-defined borders than most of the benign lesions, but this feature cannot be relied upon for diagnosis. Calcification and lamination are considered by some to be indicative of benignancy, but these features, particularly the former, have been observed again and again in bronchogenic carcinoma. Thus there is no single roentgenographic feature from which one can establish with certainty the pathologic diagnosis of a coin lesion. Indeed, a combination of features strongly suggesting a diagnosis must be reinforced by bacteriologic or histologic evidence of the nature of the lesion.

Skin tests for tuberculosis and for fungous and certain other diseases (Brucellosis) should be performed on all patients with coin lesions of unknown etiology. These tests are primarily of negative value since about 25 per cent of patients with lung cancer have a positive reaction to tuberculin, and the same is true to a lesser extent of coccidioidin and histoplasmin. Antigens for skin tests should be injected at the time of the initial examination. By making multiple intradermal injections on the volar surface of each forearm, skin tests for tuberculosis, coccidioidomycosis, blastomycosis, histoplasmosis and brucellosis can be made simultaneously.

Laboratory examinations are of little diagnostic help with the exception of studies of sputum, bronchial aspirate and gastric washings. For exclusion of tuberculosis, careful examination of smears from three consecutive 24-hour sputum concentrates and three gastric washings are sufficient. Since cultures require four to six weeks for growth, they are of

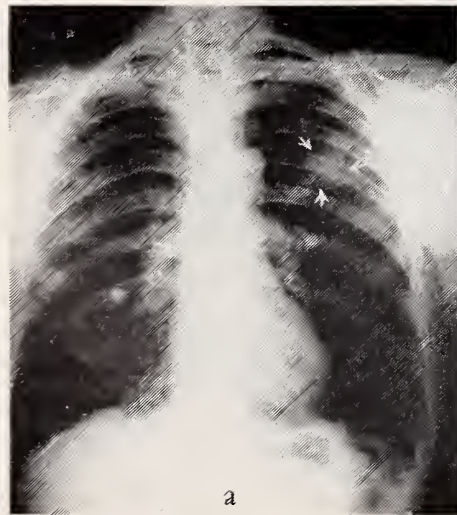


Figure 1A
Chest roentgenogram demonstrating well circumscribed nodular infiltration pro-



Figure 1B
Lateral roentgenogram revealing lesion projected over second interspace on the left, in apical-posterior segment of left upper lobe.



Figure 1C
Resected left lung containing squamous cell bronchogenic carcinoma in posterior segment.

little value in arriving at an early diagnosis. Examination of the sputum should also be made for other organisms.

Cytologic examination of sputum and bronchial secretions may be helpful in establishing a diagnosis of malignant neoplasm, but considerable experience is required for interpretation of the material. In addition, a negative report has no value in the diagnosis of coin lesions, particularly those located peripherally, since the presence of malignant cells in the sputum depends on ulceration of the bronchial mucosa with shedding of these cells into a bronchus which communicates with the trachea.

In only about five per cent of cases can the diagnosis be made by bronchoscopy. This is not surprising since the majority of coin lesions are peripheral and in the upper lobes. Indeed, this procedure yields positive results in only a third of the cases of symptomatic bronchogenic carcinoma.⁶ At bronchoscopy specimens of bronchial secretions or washings should be obtained for bacteriologic and cytologic studies.

After all diagnostic procedures have been employed, the nature of the pulmonary coin lesion still remains unknown in most instances. Therefore, since diagnosis can only be established by means of exploratory thoracotomy, this procedure is not only a form of therapy, but a diagnostic tool as well, and is being employed with increasing frequency.

The trend toward thoracic exploration to establish the pathologic diagnosis of silent lung lesions has been largely a result of the following factors: (1) The incidence of malignancy, varying from 7.3 to 38 per cent,^{21 7 15 20 17 1} is great enough to warrant consideration in any undiagnosed pulmonary nodule. In the younger age group (below 40 years) the incidence of pulmonary malignancy is about 10 to 15 per cent, whereas in the later decades carcinoma occurs in 35 to 50 per cent of cases. It has been demonstrated that cancer of the lung has a silent phase in which the lesion is more likely to be curable than one producing symptoms. Overholt¹⁹ found 35 malignant tumors among 145 silent lung lesions detected in roentgenographic chest surveys. Of these 70 per cent were resectable and without gross evidence of lymphatic extension. (2) Tuberculomas constitute a continuing hazard to the patient in spite of long-term anti-microbial therapy. Thus, even if the tuberculous nature of a coin lesion can be definitely established by non-surgical methods, excision is indicated as the most effective form of therapy. (3) Exploratory thoracotomy no longer is the dreaded procedure that it was 20 years ago. In fact the operative mortality in the treatment of coin lesions is less than one per cent—an acceptable figure for almost any major surgical operation. Thus, "observation" of an undiagnosed lung lesion is not only

illogical but is in fact contra-indicated. The responsibility of the family physician in this regard is strikingly demonstrated by the report of Abeles and Ehrlich.¹ In a follow-up study of 44 patients with single, circumscribed intrathoracic densities detected by routine roentgenographic examination, 31 patients were advised to have exploratory thoracotomy. Of these 21 were operated upon. In seven a primary malignant lesion was found, and in one the lesion was metastatic. In the remaining 10 cases operation was refused because of the absence of symptoms—by the patient in three and *by the referring physician in six*—and deferred in one because of negative bronchoscopy. That five of these 10 patients subsequently developed hopelessly advanced carcinoma serves to emphasize the tragic consequence to the patient of the physician's lack of awareness of the serious nature of the coin lesions.

Case Reports

The following case reports illustrate the necessity for thoracotomy to establish the diagnosis of coin lesions, and indicate the various pathologic conditions that may present as circumscribed, asymptomatic pulmonary densities.

MALIGNANT LESIONS

Case 1

A. W.—A 49-year old Negro male was admitted to the hospital because of pain in the left lower chest following a slight fall while playing with a child the day previously. Physical examination was non-contributory, and routine laboratory examinations were within normal limits. Chest roentgenograms revealed a nodular infiltration projected over the second interspace on the left (Fig. 1 a and b). There were dense drainage bands connecting this infiltration with the hilum. Calcification was present in both hilar regions. Bronchoscopy and cytologic studies were negative, so left thoracotomy was performed. A cylindrical mass measuring 4x2x2 cm. was found in the posterior segment of the left upper lobe (Fig. 1 c). There was no evidence of hilar or mediastinal involvement. Pneumonectomy was performed, and the pathologic diagnosis was squamous cell carcinoma. Post-operatively the patient developed an empyema for which thoracotomy was done. This patient was last seen four years after the operation with no evidence of malignant disease.

Case 2

W. H.—A 59-year old white male was referred to the hospital because a "spot" in his right lung was noted on a tuberculosis survey roentgenogram. Physical examination, bronchoscopy and cytologic studies of the sputum were negative. Chest roentgenogram revealed a solitary 1.5 cm. coin lesion in the peripheral portion of the right lung field (Fig. 2 a). Thoracotomy was performed, and a firm, nodular tumor was found in the upper lobe near the periphery extending across the oblique fissure (Fig. 2 b). A pneumonectomy was performed. The lesion proved to be squamous cell bronchogenic carcinoma.

TUBERCULOMAS

Case 3

N. L. R.—A 44-year old white male was admitted to the hospital with symptoms of peptic ulcer. The admission chest roentgenogram revealed a small rounded density just above the right costophrenic sulcus (Fig. 3 a). It appeared to contain flecks of calcium. Physical examination was completely negative, and the tuberculosis skin test was negative. Right thoracotomy was performed, and the mass was located in the lateral segment of the lower lobe. There was a similar, but smaller, nodule on the diaphragmatic surface of the right lower lobe. These nodules were excised and histologically proved to be tuberculomas (Fig. 3 b).

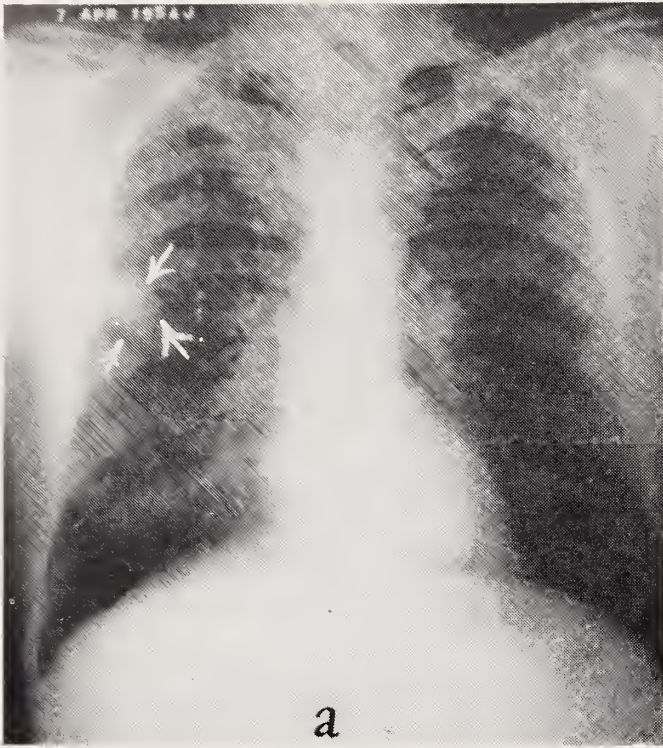


Figure 2A

Chest roentgenogram demonstrating a typical "coin" lesion in the peripheral portion of right lung field. The lesion is well circumscribed and surrounded by air-containing pulmonary parenchyma.



Figure 2B

Photograph of resected lung showing a bronchogenic carcinoma in the posterior segment of the upper lobe.

COCCIDIOMAS

Case 4

J. E. M.—A 41-year old white male was admitted to the hospital because of the incidental roentgenographic finding of a nodule in the left lung field (Fig. 4 a). He was asymptomatic. Physical examination and routine laboratory examinations were

within normal limits. Bronchoscopy and sputum examinations were negative. Skin tests for tuberculosis and coccidioidomycosis were positive. At thoracotomy a nodule 3x3 cm. in diameter was located in the left lateral basal segment of the lower lobe. The nodule was excised and proved to be a coccidioma (Fig. 4 b).



Figure 3A

Small rounded density in right lower lung field as demonstrated by admission chest roentgenogram.

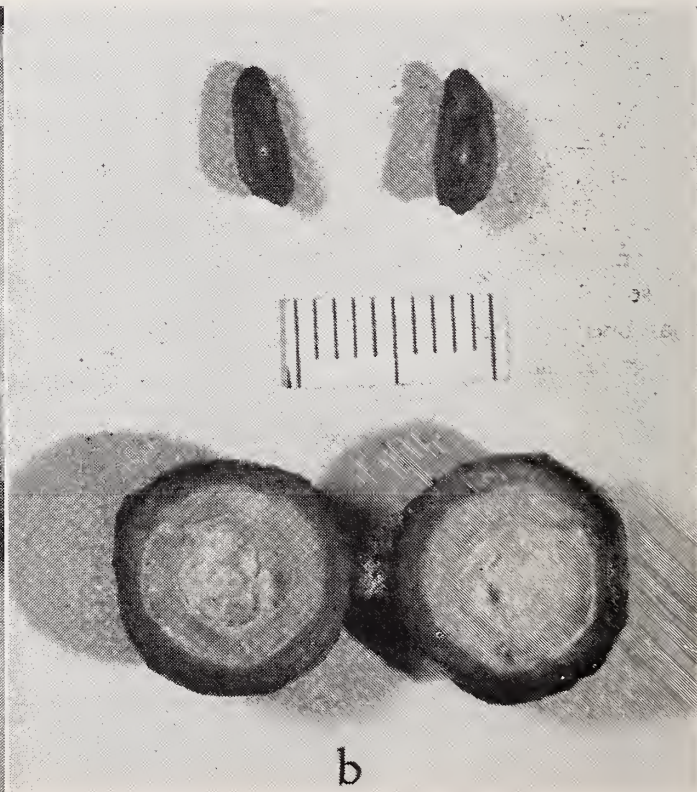


Figure 3B

Photograph of resected specimen reveals the laminated peripheral fibrous capsule with central caseous core of a tuberculoma.

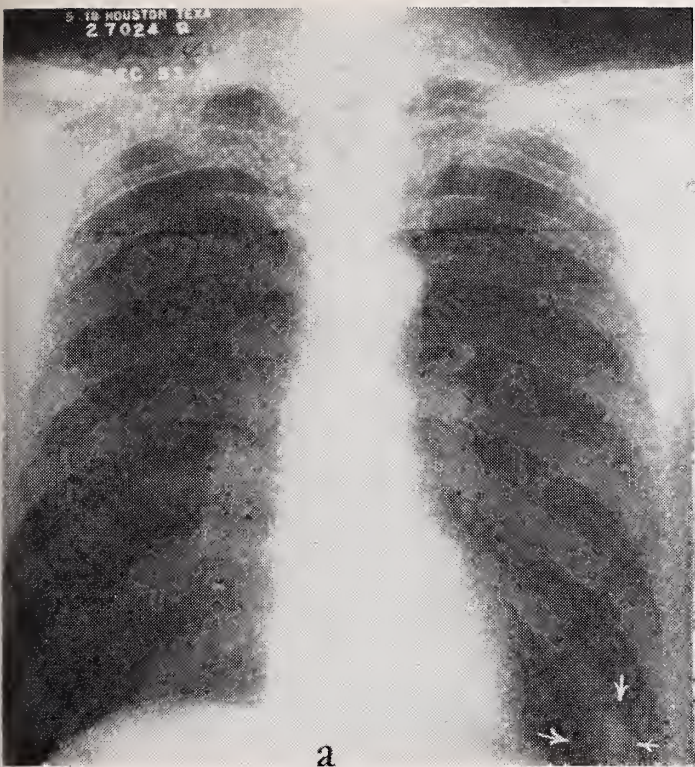


Figure 4A

Chest roentgenogram demonstrating well circumscribed "coin" lesion in left lower lobe.

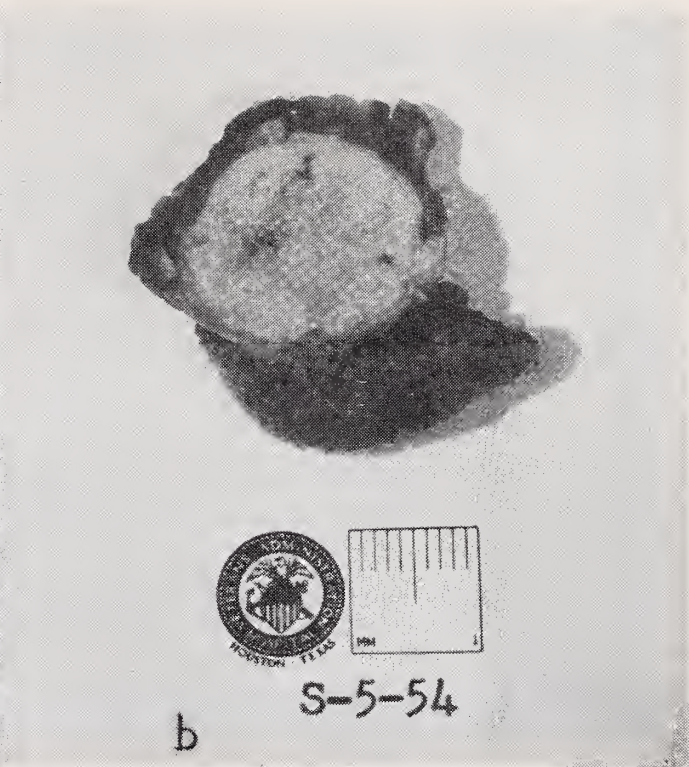


Figure 4B

Resected specimen from lateral basilar segment, proven histologically to be a coccidioma.

Conclusion

Coin lesions of the lung may be inflammatory or neoplastic, and benign or malignant. When the lesions are primary carcinomas they represent the earliest recognizable phase of that disease and one in which cure is most likely. Since diagnosis is practically impossible by any means short of thoracotomy with excision and histologic examination of the lesion, this procedure is indicated both for diagnosis and therapy of circumscribed, asymptomatic pulmonary densities. The operative mortality rate is insignificant, and postoperative morbidity minimal. The efficacy of thoracotomy in the management of coin lesions is proven, and therefore physicians should not be reluctant to advise operation.

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Pyricidin

in the Treatment of Mental Illness

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TEN PSYCHOTIC PATIENTS between 15 and 58 years of age were treated with Pyricidin for a period of six weeks at Charity Hospital of Louisiana, New Orleans.

Thorough psychiatric study before and immediately after completion of treatment gave special attention to thought content, affect, intellectual ability, perception, behavior, insight, and to the patient's plans for the future. Just prior to the beginning of medication and immediately after it was discontinued, eight of the 10 patients were given psychological tests: the Rorschach, human figure drawings and three sub-tests of the Wechsler-Bellevue Intelligence Scale (Information, Comprehension and Similarities). Form I of this Scale was issued initially and form II finally.

Three of the patients had had electro-convulsive therapy. No patient was started on Pyricidin until shock therapy had been discontinued for at least one month. No control was studied.*

Case 1

Female, age 58. *Reactive depression*. The following conclusions were drawn from psychiatric examination: after medication things seemed more real to the patient, insight was improved and plans for the future were more realistic. Much of the hostility toward her husband shown in the beginning of the experiment had been lost, thought content was less depressed, there was no change in affect or behavior. Psychological tests revealed improvement: the second drawings were better based and more detailed and the Rorschach performance was more spontaneous. Tests after medication revealed more anxiety regarding sexuality.

Case 2

Male, age 15. *Paranoid schizophrenia*. When first seen the patient had delusions of things crawling on him, and he heard

people groaning. There was some disappearance of the flat affect shown originally and slight improvement intellectually. Perception, attention and comprehension were improved; insight remained the same. In the beginning this patient had no plans for the future; after medication he stated he planned to go to school as soon as possible after he was released from the hospital; if necessary, he would get a job until the next school term was to begin. At the beginning of medication he was disoriented in all fields. After medication he was oriented for time, place and person. Psychological examinations did not show much change following medication, although the second Rorschach and drawings showed more spontaneity, the Wechsler score dropped somewhat.

Case 3

Male, age 21. *Schizophrenia*. Patient was actively hallucinating in the auditory field when first examined and had delusions of ruining his church. He was completely disoriented in all the fields, intellectual capacity and judgment were poor, and the patient was depressed. He had no plans for the future. After the medication there were no hallucinations, but the patient had severe nightmares in which he saw many people who were bloody and injured. The delusion of ruining his church had vanished and things seemed more real. He was oriented for time, place and person; there was slight improvement in memory and less depression. Psychological examination was not done on this patient.

Case 4

Male, age 20. *Schizophrenia*. Delusional and hallucinating prior to medication, the patient showed a flattened affect and periods of depression with frequent crying. After medication there was no crying, and the patient did not appear depressed. He moved about more on the ward and socialized better with the patients. He seemed to verbalize better and smiled more frequently. Psychological tests showed improvement: originally untestable (a mute catatonic), there was after medication some slight productivity with a Wechsler Information test.

Case 5

Male, age 29. *Catatonic schizophrenia*. When first seen the patient sat quietly on the ward pointing and glaring and beating on the table frequently. He coined words and picked at his ears continually but was mute throughout all the interviews. What verbalization he showed was a guttural, animal-like sound. After medication the patient appeared less anxious; he did not beat on the table but still was out of contact and coined new words. Psychological tests revealed improvement, since he was originally untestable; he produced some drawings on the second test.

Case 6

Male, age 18. *Paranoid schizophrenia*. Patient had had two complete series of electro-convulsive therapy with little effect. When seen, he informed the examiner that occasionally he felt like crying but he thought his mind was all right, yet he could see where others might think it was bad. He was unable to do simple multiplication; toward the end of the testing, when he became tired, he failed miserably in all the tests. While his memory was poor, he was oriented for time, place and person. He hung his head on his chest and played with his hands during the interview; he voiced suspicions of his wife because she was working in a public office. He thought that his mother was influencing him and tampering with his mind. Attention, perception and comprehension were poor. Given treatment for three weeks he left the hospital before the course of therapy was completed. When he left the hospital there was slight improvement in his depression, but no change in his delusions or memory.

*In the optimal situation for experimental test, three groups, if possible matched for age, approximate psychiatric condition, socioeconomic status, etc., would be studied in order to test the effect of the "experimental" or independent variable (in this case Pyricidin).

The experimental group would be administered the drug as indicated. One control group would be administered a placebo at the same intervals and under the same circumstances. A second control group would receive no medication.

Each group would be studied over the same period of time psychiatrically and psychologically by observers who knew nothing of the patients belonging to the experimental (Pyricidin) or control (placebo and no medication) groups.

The author was assisted in the psychological testing by Thomas Richards, Ph.D., Thelma N. Johnson, Frank Loeffler, of L. S. U. School of Medicine, New Orleans, La., Department of Psychiatry.

Case 7

Male, age 42. *Paranoid schizophrenia*. Patient showed hallucinations and delusions before and after medication. Affect before medication was flattened and more appropriate afterwards. There was no change intellectually, but after the treatment the patient was less talkative, and his speech was more coherent. There was no change in insight. The psychological evaluations showed improvement: the second performance revealed less anxiety, less paranoid tendency and a healthier concept of masculinity.

Case 8

Female, age 21. *Paranoid schizophrenia*. Patient was extremely paranoid, delusional and hallucinating prior to the medication. She also showed a flattening of affect and was mute. After medication she showed some speech blockage, and her speech was irrelevant but coherent. After the medication she was oriented for place and person, but not for time. Psychological test showed improvement, the second Rorschach performance was more realistic and productive.

Case 9

Female, age 38. *Paranoid schizophrenia*. This patient showed no improvement clinically after medication. She had had 19 electro-convulsive therapy treatments previously with no improvement. Psychological tests were not done with this patient.

Case 10

Female, age 26. *Simple schizophrenia*. Although on psychiatric study after medication she showed no improvement, psychological evaluation indicated that the patient was less anxious; she showed less aggression but greater isolation and withdrawal.

Summary

Ten psychiatric patients were given Pyricidin over a six weeks period. During this period of medication five patients (50 per cent) showed improvement in both psychiatric and psychological examination (patients No. 1, 4, 5, 7, 8). One patient (No. 3), not examined psychologically, showed improvement from the psychiatric viewpoint.

Two patients (No. 2 and 10) gave evidence of improvement in either the psychological or the psychiatric examination, but not both.

Two patients (No. 6 and 9), both paranoid, gave no evidence of improvement. Since no control group (without Pyricidin) was studied, it is impossible to associate the improvement of 60 per cent of the patients with the drug; it is clear the 60 per cent were improved after six weeks of this treatment.

384 Peachtree Street, N. E.

Medical Scholarships

ALL GEORGIANS CAN TAKE pride in the program being carried out by the State Medical Education Board.

Through the efforts of this agency not only are worthy Georgia youths being aided to obtain educations but also small Georgia communities are receiving assurance of the much-needed services of physicians.

The Medical Education Board was created by a Constitutional Amendment adopted by the General Assembly in 1951 and ratified by the voters in 1952. It began its operations on April 1, 1953, and its first report, just recently issued, shows its members have been diligent in the discharge of their duties.

Under the terms of the Amendment creating it, the Board is authorized to grant scholarships to worthy Georgia youths to attend medical college. These scholarships may total as much as \$5,000 to any one person paid in annual installments of up to \$1,500 per year.

To receive one of the scholarships, a medical student must show need for financial assistance and agree to practice in a community designated by the Board for five years after the completion of his internship. Communities in need of a doctor may apply to the Board for assignment of one of the future doctors.

The Board granted 25 scholarships for the 1953-54 academic year and 28 for 1954-55. The recipients of the 1953-54 scholarships were picked from among 68 applicants; those for 1954-55, from among 63 applicants.

Scholarships went to 21 white and four Negro medical students for 1953-54 and to 26 white and two Negro students for 1954-55. The Board hopes to increase the number of scholarships in force to a maximum of 100, a goal to be reached during the 1956-57 fiscal year. That year the first scholarship class will graduate and the cycle can then be repeated.

When the program reaches its maximum of 100 scholarships it will cost the State \$150,000 per year.

Georgia could make no more profitable investment in the future. Through this program she is training the most capable of her youth and at the same time serving the medical needs of her people.

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Altered Respiratory Physiology in Patients with Chest Disease and the Effects on the Conduct of Anesthesia

COLONEL HARVEY C. SLOCUM, M. C., U. S. A., Washington, D. C.

THE PATIENT WITH disease processes involving the pulmonary mechanisms may be subjected to surgical treatment. The operative procedure may be in relation to or incidental to the pulmonary disease. In the management of anesthesia for this group of patients the anesthesiologist is concerned with the factors which alter pulmonary ventilation and gaseous exchange across the alveolar membrane.

A brief outline of both intra-pulmonary and extra-pulmonary disease processes provides a working basis for consideration of the problems to be discussed.

A. *Intra-pulmonary Diseases considered:*

1. *New growth*—Benign, malignant.
2. *Congenital defects*—Cyst, atresia, agenesis, arteriovenous fistula.
3. *Infection*:
 - a. *Acute*—Tracheobronchitis, pneumonitis, abscess, pleurisy, empyema.
 - b. *Chronic*—Bronchitis, bronchiectasis, tuberculosis, granulomata, bronchopleural fistula.
4. *Functional*—Foreign body, asthma, edema, emphysema, atelectasis, fibrosis, pneumoconiosis, pulmonary arteriosclerosis, vascular congestion.
5. *Trauma*:
 - a. *Mechanical*—Fractured ribs, lacerated lung, pneumothorax, ruptured diaphragm, phrenicectomy.
 - b. *Chemical*—Smoke, gases, burns, ACE.

B. *Extra-pulmonary Disease:*

1. *Tumors*—Esophagus, Thymus, Mediastinum.
2. *Mechanical*—Aneurysm, adhesions, lymph nodes, aberrant vessels, diaphragmatic hernia.

Discussion

The physiopathological variables of pulmonary disease involving the air passages, the parenchymatous

tissues, the alveolar membrane and the pleura are considered in relation to the conduct of anesthesia.

I. *Metabolic and Nutritional* factors are important in the anesthetic management of the patient with pulmonary disease.

1. Febrile states due to acute infection demand an increased supply of oxygen.
2. Malignancy and infection always increase the risk of operation due to general debilitation and lowering of resistance to trauma.
3. Blood deficiencies such as anemia, low blood volume and hematocrit decrease the O₂ carrying power of the blood and the patient is more susceptible to circulatory depression and shock.
4. Protein metabolism may be subnormal due to secondary liver disease. Fluid balance and healing are intimately tied in with this function. Instances of pulmonary edema are more prevalent when protein levels are low.
5. The acid-base balance may be completely upset by over-demands made on the buffer system to combat acidosis. The oxygen uptake and CO₂ elimination by the tissues are controlled by this mechanism.
6. In many instances circulatory depression is secondary to respiratory inadequacies. Low O₂ tension and high CO₂ tension from poor ventilation or gaseous diffusion, particularly associated with the depression of anesthesia, reduce cardiac output and lead to a state of shock.

II. *Respiratory Obstruction* before, during or after operation may seriously alter respiratory physiology.

1. Tumors, cysts or enlarged lymph nodes may involve the tracheobronchial tree intrinsically or extrinsically causing mechanical blockage of the air passages. Infection and accumulated secretions may be trapped in the terminal portions of the bronchi rendering that portion of the lung useless.

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Read before the Joint Session on Internal Medicine and Thoracic Diseases—Medical Association of Georgia—Annual Session, May 4, 1954.

Congenital cysts of the bronchi may form in the prenatal state. Respiratory embarrassment may occur as the cyst grows to obliterate or compress the lung field. They may be discovered incidental to other pathology.

2. Foreign bodies from internal or external origin may occlude a major or minor bronchus. Inhalation of smoke, gases, and irritating chemicals may cause pulmonary edema or excess secretions sufficient to cut off adequate oxygenation.
3. Mucus, pus, blood and fluids may originate from lesions in the lung such as tuberculous cavities, abscesses, bronchiectasis, tracheo-bronchial fistula connected with an empyema abscess, and traumatic rupture of lung tissue. Too frequently patients have drowned in their own secretions.
4. The ciliary mechanism becomes inactive following the administration of depressant drugs and anesthetic agents so the possibility of accumulated bronchial secretions must always be kept in mind.

III. *Ventilatory Deficiencies* limit the exchange of respired air to and from the lungs.

1. Mechanical limitations of the chest cage and diaphragm decrease the vital capacity of the lungs.
2. Central respiratory depression from pain relieving drugs may be an important limiting factor to respiratory exchange.
3. Intrinsic involvement of the air passages, pleural structures and parenchymatous tissues may render large areas of the lung field useless thus decreasing the functional residual which is so important to the diffusion mechanism of respiration.

IV. *Gaseous Exchange* across the alveolar membrane is the mechanism of supplying necessary oxygen to the tissues and removing CO₂ as a waste product.

1. Destruction of the alveolar structure by trauma, infection, fibrosis and pressure render large areas of the gaseous exchange mechanism useless. Impairment by infection, edema, and hemorrhage may have a temporary effect with even more serious physiological effects.
2. As vital capacity and functional residual are decreased the patient becomes more static due to dyspnea, cyanosis and hypoxia associated with exertion. In contrast, patients with emphysema have an increased functional residual. Hyperfunction of increased bronchial muscle, hypertrophied glands and bouts of periodic

edema of the mucosa cause a narrowing of the air passages. As this condition progresses expiration becomes deficient in relation to inspiration. The associated pressure produced by effort of respirations and coughing destroys the elasticity of the lung tissue. Gradually the effective diffusion of gases is lost due to marked increase of dead space unaffected by ventilation.

In the emphysematous patient the exchange of oxygen and CO₂ is acutely impaired. Respiratory acidosis may be severe, and CO₂ retention in the tissues may be such that sudden removal or displacement with oxygen by pressure breathing may cause a complete circulatory collapse.

V. *Vascular problems* are intimately concerned with lung pathology as the alveolar vessels function for the purpose of gaseous exchange between the lung and blood stream.

1. Pulmonary arteriosclerosis may impair the blood flow through the lung due to reduced capillary bed or narrowed pulmonary artery. This may be associated with generalized arteriosclerosis or secondary to severe emphysema. The result is an inadequate circulating volume of oxygenated blood put out by the pulmonary system. Oxygen saturation of arterial blood decreases and mild hypoxia exists.
2. Cor Pulmonale is characterized by pulmonary congestion associated with a dilated heart. This may be secondary to pulmonary arteriosclerosis and emphysema. In cardiac conditions the use of excessive gas pressures against the pulmonary bed may have a dangerous tourniquet effect between the left and right heart cutting down the input to the left heart with decreased cardiac output and hypotension. In the damaged heart back pressure on the right side may cause acute dilatation and failure.
3. Pulmonary embolus may kill or cause acute circulatory collapse. Severe vascular spasm of the entire lung field may produce immediate and severe shock. On occasion sympathetic block will release the vascular constriction permitting surgical removal of the embolus. Infarct may cause a similar picture with the involved portion of the lung becoming congested and useless for purposes of oxygen transport.
4. Pulmonary edema may decrease gaseous exchange with fatal results. The interstitial tissues may be boggy and thickened as in asthma. The vascular bed may liberate quantities of humoral fluid from the blood stream into the

alveolar air spaces. Changes in osmotic pressure of tissue fluids, from protein deficiency, congestion of the vessels from heart disease, variation in integrity of the vessel walls from chemical or bacterial toxins, excess negative pressures within the lung field and other factors may establish this condition.

As edema is apt to be a generalized condition involving the entire alveolar bed the gaseous transport must be supported with positive pressure oxygen until the fluid obstruction is cleared and adequate circulation is restored.

5. Congestion of the lungs associated with heart disease is common and as audible rales may be noted to shift in relation to gravity. Support of the circulatory function of the heart is necessary to clear this condition.

VI. *Neurogenic problems* usually involve the reflex control of breathing, bronchiolar constriction and cough reflexes.

1. The neurogenic control of the bronchi may initiate the pathology of asthma by cholinergic stimulus. Edema of the subepithelial layers of the mucosa, constriction of the bronchial musculature and abnormal output from the mucous glands cause restriction of the air passages, obstruction to air flow and gradual breakdown of elastic fibers. The end result may be comparable to emphysema plus mucus obstruction.
2. Reflex bronchiolar spasm may occur from stimuli to the tracheobronchial tree by foreign substances or by manipulation of the hilar structures. Allergic manifestations frequently cause severe bouts of hypoxia and are usually the bronchoconstrictor response to histamine.

3. The use of barbiturates for sedative or anesthetic purpose may cause these reflexes to be more sensitive to stimuli and indirectly cause a marked decrease in respiratory exchange.
4. The cough reflex is ever important in conjunction with the ciliary mechanism to perform the janitor service of the respiratory tree. Depressed cough reflexes may permit the accumulation of secretions in the air passages. Hyperactive cough reflexes may interfere with the efforts to conduct a smooth anesthesia. Also uncontrolled cough may cause contralateral spread of infected bronchial secretions. In the presence of partial bronchial obstruction the cough mechanism is responsible for trauma to the air sac and alveolar membrane.
5. The Herring-Brauer reflex serves as a functional part of the respiratory mechanism. Overdistention of the alveolar bed may inhibit temporarily the cycle of respirations. This procedure is used in the production and maintenance of controlled respiration in patients under properly balanced anesthesia.

In review of the disease processes affecting the physiology of respiration it may be seen that the anesthesiologist must have not only a thorough knowledge of anesthetic drugs and technics but an understanding of the patho-physiological variables associated with each condition. He must be prepared to establish and maintain an adequate airway to the functional area of gaseous exchange and protect this function against all complicating factors. Only on this basis can the seriously ill be protected and safely guided through the exigencies of surgical intervention.

*Office of the Surgeon General
Department of the Army*

Simplified Insurance Claim Form Approved

APPROVAL HAS BEEN granted by AMA's Council on Medical Service to a simplified insurance claim form drafted by a special committee of the Health Insurance Council. AMA's Committee on Prepayment Medical and Hospital Service collaborated with the HIC committee. The form is designed for use in administering surgical expense benefits under group insurance. Physicians who practice in areas where this type of insurance coverage is prevalent should be particularly interested in this development.

Eventually the Health Insurance Council hopes to have about six insurance blanks available to accommodate the various types of benefits. Only this form (GS-1) has been approved by AMA to date although the Council on Medical Service has suggested certain modifications in a second which has been approved "in principle."

Copies of this form may be secured from the Council on Medical Service.

Testicular Tumors

DAVID C. WILLIAMS, JR., M.D., Augusta, Ga.

FROM THE VOLUME OF the literature on this subject one would think that these tumors are not so infrequent, yet they occur at a rate of approximately one in 1,500 neoplasms of the male.¹ The reason for so many articles on this subject is probably their bizarre nature and the intrigue of their histological features. During the past year we have seen seven cases. This is not a large series, and it is not sufficient to draw any elaborate conclusions.

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The reason for the presentation, therefore, is that that there has been much discussion as to the classification of these tumors, the diagnosis and the treatment. Within the past few years there has been a further trend towards a more radical surgical¹⁰ and radiological⁷ approach to these tumors. The largest collection of these tumors has occurred during the past decade in the armed services in which time they collected 1,106 cases, of which 960 were teratomas.² The highest age incidence of these tumors is in the third and fourth decades of life.

To classify these tumors we prefer the classification of Herbut,³ as follows: (1) testicular tunic tumors, (2) benign tumors, (3) malignant epithelial tumors (over 90 per cent), (4) sarcomata, (5) Leydig cell tumors, (6) Sertoli cell tumors and (7) secondary tumors. The malignant epithelial tumors are subdivided by Dixon & Moore,² as follows: (1) seminoma, pure, which has an incidence of approximately 30 per cent in the series with five year mortality of six to 10 per cent, (2) embryonal carcinoma, pure or with seminoma, or chorio carcinoma with an incidence rate of 26 per cent and a mortality of 58 to 60 per cent, (3) teratoma, pure, with an incidence rate of nine per cent and a mortality rate of 28 per cent, (4) teratocarcinoma with which it may have mixed embryonal carcinoma, seminoma or choriocarcinoma with an incidence rate of 32 per cent and a mortality rate of 49 to 60 per cent, (5) choriocarcinoma with an incidence rate of one per cent and a mortality rate of 100 per cent. These tumors arise from totipotent cells and may show any combination of the above five morphological patterns. Others have classified these tumors as teratomas—that may show any phase of differentiation of the totipotent cells.

The cause is unknown as it is in other tumors. Because these tumors occur more frequently in the

young adult male during the time of greatest sexual activity, it is only natural that one would suspect a hormonal influence. There has been listed also a slightly higher frequency in cryptorchidism, yet in the series by Carroll⁴ of 550 crypt-orchids only six tumors were found. Trauma has often been listed as a probable cause, but in truth it is probably the first factor that focuses the attention of the individual on the new growth. Also this gives him a psychological outlet for palpation of his own orchids. Experimentally (Falin,⁵ Carlton, Friedman and Bomze⁶ produced teratomas in the rooster by injection of 10 per cent zinc chloride around the testicular capsule. Experiments showed the earliest form to appear as an embryoma, then a teratoid differentiation took place.

Histogenetically these malignant epithelial tumors arise from totipotent cells and Mellicow⁸ and Milton Friedman,⁷ with others, offer an acceptable theory that these teratoid tumors arise either as: (1) rests of trigeriminal blastomeres of the fertilized ovum prior to actual differentiation into the different germ layers, (2) they may arise from actual sperm cells undergoing autofertilization. In some of the tumors reviewed by Dixon & Moore they were able to see the following: a nearly proliferation of a blastular stage similar to an eight to 12 day human embryo, that is there may be an inner cell mass, an embryonic plate and an outer layer of primordial germ cells.⁴

The differential diagnosis may at times pose a real problem because some of these tumors may be only microscopic with wide-spread metastasis, in fact, in some series there was distant metastasis in 65 per cent by the time the tumors were first diagnosed. Generally a mass may appear in the testicle which may have been present for a few weeks or years depending upon the type of growth. The only pain these individuals have is from the heaviness and the increased size of the testicle or pressure from hemorrhage into the tumors. Late symptoms may be headaches, backaches and abdominal cramps which usually appear along with weight loss and malignant cachexia. In some series epididymitis had been misdiagnosed in 35 per cent¹¹ of the cases. A hydrocele or a spermatocele may be present, and in either case it should be aspirated. Bimanual palpation should be carried out, if necessary under anesthesia. Whenever there is any question of doubt, these masses should be explored. Inflammatory and traumatic conditions can usually be differentiated by palpation, physical

Presented at the 104th Annual Session of the Medical Association of Georgia, May 2-5, 1954, Macon, Ga.

changes, laboratory studies, X-rays, skin tests and biopsy.

Metastasis occurs mostly by the lymphatics. The lymphatics of the testicle are the deep and the superficial groups. The deep group drains the testicular tissue and follows the course of the vessels in the cord and retroperitoneal areas. The superficial group drains the tunics of the testicle. On the left side, the first barrier for metastasis would be the lymph nodes at the hilus of the kidney, the junction of the spermatic and renal vein; on the right side, the periaortic lymph nodes at the junction of the spermatic and vena cava. Thus the retroperitoneal gutters would be the first site of early metastasis unless the blood vessels were involved or invaded.

Case Reports

Case 1

September 1953, a 65-year old white male in the State Mental Hospital presented himself with a large mass of the right testicle, extremely hard and of unknown duration. This mass measured $4\frac{1}{2}$ by $2\frac{1}{2}$ inches. X-ray and laboratory examinations were negative. Prostate showed grade I benign enlargement, he also had generalized arteriosclerosis with psychosis, moderate hypertension 155/95. Under local anesthesia the mass was removed, and this proved to be a partially calcified hematocoele. This case is presented as a differential diagnostic problem because it appeared grossly similar to a teratoma.

Case 2

January 1953, a 57-year old colored male presented himself with a non tender swelling of the testicle which had gradually increased in size for a period of one year. Patient also showed symptoms of prostatism, which had been present for approximately six months, and weight loss of about 30 pounds in a year. He was poorly nourished, fairly well developed, with weight 140 pounds, height 69 inches, blood pressure 170/110, left inguinal hernia and a marble sized mass (one cm.) on the anterior surface of the right testicle. Prostate was indurated, fixed and clinically suggestive of carcinoma with metastasis to the seminal vesicles; this was proven by biopsy. Phosphatase levels and X-rays were negative. Bilateral orchiectomy for carcinoma of the prostate and biopsy of the testicle were done. Mass of the right testicle measured approximately two cm. in diameter and was confined with the capsule of the testicle. It appeared grossly fibrous and glistening white. Microscopic examination of this mass showed minute spaces separated by collagen. It was classified as an adenomatoid tumor, so termed by Golden and Ashe. This is generally considered a testicular tunic tumor.

Case 3

December 1952, a 42-year old white male presented himself with the complaint of fever of five to six days duration. He had a history of recurrent bouts of hepatitis since 1944, atrophy of the right testicle since 1943 from mumps and treatment for past eight months for chronic epididymitis of the atrophic testicle. Physical examination was negative except for atrophy of the right testicle, an indurated area with a diameter of one cm. in its upper pole and moderate enlargement of the liver. Laboratory and X-ray examinations were negative. Under local anesthesia the atrophic testicle on the right was removed and proved to contain a seminoma replacing the upper pole. Then the remainder of the cord and the iliac nodes were removed, but no metastasis was found. Also he was treated with X-ray. Patient is still alive and doing well.

Case 4

November 1952, a 55-year old white male cachectic and psychotic was seen by the staff at the State Mental Hospital. Examination had disclosed a large right inguinal and scrotal mass believed to be an incarcerated hernia. Exploration disclosed a large tumor $16 \times 8 \times 6$ cm. The mass was friable from hemorrhage and necrosis in some areas and fibrous in other areas. Microscopic examination showed this to be a dark staining tumor mass containing cords of epithelial cells and trophoblastic cells. There was invasion of the lymphatics and blood

vessels with neoplastic cells. Diagnosis was embryonal carcinoma of the testicle with some terato and choriocarcinomatous elements. Patient showed multiple metastasis to the lungs, and he died in a period of six weeks. This represents a case that was operated first because of apparently incarcerated hernia. Patient was psychotic and no history was obtainable preceding his operation.

Case 5

May 1953, a 28-year old white male, well nourished and developed, presented himself with a globular mass of the right testicle, and this was reported as having slowly increased in size in three months. The testicular mass measured approximately $2\frac{1}{2}$ by 2 inches, was heavier and larger than its mate, and it did not transilluminate light. Patient had no symptoms of pain or tenderness. Remainder of the physical examination, laboratory and X-ray examination negative. On May 5, 1953, a right orchidectomy with removal of the iliac lymph nodes was done, and these nodes showed no involvement. Patient refused retroperitoneal dissection. He is still active and showed no evidence of metastasis recently.

Case 6

In September 1953 a healthy, well developed and well nourished 31-year old white male presented himself with the history of swelling of the left testicle for a period of approximately six weeks. He believed it occurred following an injury. This mass of the left testicle measured about $2\frac{1}{2}$ by 2 inches, was markedly heavier and larger than the normal testicle on the other side. It was only moderately tender to palpation and the epididymis was not remarkable. There were no areas of hemorrhage or discoloration of the scrotum. Prostate and remainder of the physical examination were negative as were X-rays and laboratory examination. Family history revealed one maternal aunt died of a cancer of the ovary. In October 1953 this patient first had a biopsy made of the left testicle in view of the previous trauma. A frozen section was made of this whitish tumor mass, and it was classified as a seminoma completely replacing the testicle. Five days later, the remainder of the cord was removed and a radical retroperitoneal dissection of the lymph nodes carried out after the manner described by Lewis. There were found only three involved nodes on the left side, the largest of which was approximately two cm. in diameter, hemorrhagic and friable. The other two were about one cm. in diameter. The two cm. node contained almost wholly two phoblastic elements. The second was a pure seminoma and a third apparently represented a teratocarcinoma with bronchogenic elements. The involved nodes were found adjacent to the left renal vein at the entrance of the spermatic to renal vein. This case definitely demonstrated the peculiarities of these tumors in that the primary tumor appeared, after multiple sections, to be a pure seminoma and the metastasis changed. The patient was further treated with X-ray therapy. Repeated chorionic gonadotrophin studies have been negative.

Case 7

In October 1953, a 26-year old white male presented himself with a mass in the left testicle. The left testicle was swollen, indurated and rather tender to palpation. For approximately four weeks he had been suffering from pain in this testicle with chills and fever and gross pyuria, and this was the reason for the previous physician's treatment for epididymitis. This testicular mass measured about $2\frac{1}{2}$ by 2 inches, was much heavier than its mate and two times its size. The epididymis could not be definitely outlined. Laboratory, X-ray and the remainder of the physical examination was physiological. On November 5, 1953, the patient had a left orchidectomy and a retroperitoneal dissection of the lymph nodes after manner devised by Lewis.¹⁰ The incision for this operation began at the scrotum and extended obliquely across the abdomen to tip of the 12th rib, and then it followed its lower border transversely to the mid axillary line. The iliac nodes were removed, then the periaortic nodes and retroperitoneal nodes to the hilus of the left kidney. There were found three nodes, the largest of which was approximately $1\frac{1}{2}$ cm. in diameter. These nodes were found at the junction of the renal vein and the spermatic vein. These nodes were similar to the primary tumor and had not shown up on previous pyelograms. They were teratocarcinoma with some trophoblastic elements.

From these cases it appears evident to us that the most sensible treatment which has been advised

lately has been adopted at the Walter Reed Hospital.¹¹ It is orchidectomy and retroperitoneal node dissection on the earlier cases plus X-ray up to 5000 R. They have not had an operative mortality, and the five year mortality rate has improved. We will note that these tumors may arise as pure seminoma. The metastasis, though not apparent usually occurs at the first lymph node barrier, namely on the left side at the junction of the spermatic vein with the renal vein, and on the right occurs at the site of the entrance of the spermatic vein and vena cava, the periaortic lumbar lymph nodes. From this it would appear that the tumors on the left side would have a better prognosis than on the right side because it would be more difficult to remove the periaortic meshwork of nodes. It is believed that retroperitoneal node dissection should be used on selected cases for three reasons: (1) these are young men who tolerate surgery well, (2) this is not too difficult a procedure, and (3) because these tumors may appear relatively mild, but the metastasis may show multiple changes. The seminoma is relatively radio-sensitive whereas the others are radio resistant. There were two cases of seminoma in this series classified as pure in the primary tumor, but one of these showed changes of trophoblastic and teratocarcinomatous elements. There was one case of teratocarcinoma showing metastasis with trophoblastic elements. Two cases had been treated previously for epididymitis. Two cases were studied pre and post operatively for chorionic gonadotrophins, but they were negative even though they showed trophoblastic elements. There was one adenomatoid tumor and one partially calcified hematocele.

Summary

In summary we wish to state that we are reporting on seven cases of one year's duration. We prefer the classification of Dixon & Moore.² We have discussed something of the etiology and the theory of histogenesis—whenever a doubt arises about a testicular tumor, exploration should be carried out. Retroperitoneal node dissection in selected cases seems to be indicated. Irradiation therapy should be given through a competent roentgenologist.⁷ Adequate laboratory and X-ray facilities, including chorionic gonadotrophin studies, should be used for diagnostic and follow up studies.

We express our appreciation to the staff at the State Mental Hospital for their help and the Veterans Administration Hospital in Columbia.

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The AMA to Meet in Atlantic City

PHYSICIANS ATTENDING the AMA's 104th Annual Meeting June 6-10 in Atlantic City may not have much time for casual strolling along the boardwalk, but they'll find ample opportunity for catching up on the latest discoveries in medicine. AMA has lined up nearly five full days of lectures, scientific and technical exhibits and color television and motion picture presentations to give you a good "short course" in postgraduate medical education. Between 13,000 and 16,000 physicians are expected to attend the convention which will center its activities in the Atlantic City Auditorium and adjacent hotels. Headquarters will be at the Traymore hotel where the House of Delegates will convene.

Outstanding scientific features include: A report on the Salk polio vaccine trials at a joint meeting of the sections on pediatrics and preventive medicine;

a general discussion of resuscitation of the newborn for the sections on anesthesiology, diseases of the chest, general practice, obstetrics and pediatrics; exhibit-symposiums on rheumatism and diabetes; fracture and fresh pathology exhibits, and a new "Queries and Minor Notes" feature in which consultants from all branches of medicine will be on hand in convention hall to answer physicians' questions concerning specific cases. In addition, the Air Force will demonstrate its "flying infirmary" on the beach in front of the Auditorium throughout the week.

More than 325 scientific exhibits and 350 technical exhibits will be on display. The color television program will present interesting surgical and clinical demonstrations piped directly into the Auditorium from Philadelphia hospitals.

Third Trimester Bleeding

WILLIAM C. SHIRLEY, M.D., FRANK C. STORY, M.D., and DAVID STROUPE, M.D., Augusta, Ga.

THE MOST IMPORTANT causes of bleeding in the third trimester are placenta previa and premature separation of the normally implanted placenta. Cervical erosion, carcinoma of the cervix, polyps and ruptured uterus all on occasion may give rise to bleeding of varying amounts.⁴ This is a report of how these conditions were diagnosed and treated at the Macon Hospital from July 1, 1951, until February 1954, a period of two years and seven months.

Placenta previa is a condition of the third trimester of pregnancy which places the mother and fetus in extreme danger from maternal exsanguination.¹⁰ Statistics vary considerably as to the frequency of occurrence of this condition. Torpin states in his textbook¹⁰ that placenta previa occurs about 0.5 to 1.0 per cent. Mengert⁸ of the Parkland Hospital, Dallas, Texas, lists .44 per cent. In two years and seven months at the Macon Hospital there were 7,963 deliveries, 57 of which were placenta previa or 0.7 per cent.

Many theories have been advanced as to the etiology of placenta previa, none of which has been proven. It is the opinion of the Macon Hospital obstetrics and gynecology staff that the most common cause, if not the only one, is that of chance. The definitions listed below are well understood by most physicians and are used in this presentation for reasons of uniformity and convenience. If the lower edge of the low implanted placenta does not reach the internal os, the condition is known as low implantation of the placenta or lateral placenta previa. If the lower edge of the placenta reaches the margin of the internal os, it is commonly called marginal placenta previa. When the placenta covers a portion but not all of the os the condition is known as partial placenta previa. When the placenta covers the entire opening, it is termed central placenta previa.⁷ Out of the 57 cases listed, there were 12 centrals, 30 partials, eight marginal, and seven low implantations.

Painless bleeding in the last trimester is the classical symptom of placenta previa, but the ultimate diagnosis depends upon palpation of the placenta above the cervical canal by sterile vaginal examination in the operating room to permit immediate,

proper treatment of all possible complications. Placenta previa must, of course, be differentiated from premature separation of the placenta. It should be borne in mind that patients with abruptio placenta frequently do not have pain. Wallace stated that as high as 49 per cent of his premature separations had no pain.¹⁰ Upon arrival at the hospital, the patient bleeding late in pregnancy should be typed and cross-matched for an adequate amount of blood. A careful history should be taken and the patient's general condition, as well as the status of the fetus, should be determined. If the patient's condition permits, a lateral film of the uterus should then be made. If the placenta can be visualized on the anterior or posterior wall of the uterus, the diagnosis is evident. If not, the degree of engagement of the presenting part and its location in relation to the promontory of the sacrum and symphysis pubis should be evaluated. If there seems to be some interference to engagement of the presenting part, sterile vaginal examination of the cervix is carried out in the operating room with cesarean section set-up available. Systematic examination of the cervix may disclose unmistakable evidence of central placenta previa or lateral implantation. With this evidence at hand one may plan intelligently for the future management of the case.

Too much emphasis cannot be placed on having adequate blood available for placenta previa patients. It is felt at the Macon Hospital, aside from replacing blood lost, that the basic management of placenta previa should be artificial rupture of the membranes if accessible and a tight abdominal binder, but cesarean section, preferably low cervical section, if central previa is present and the fetus alive. In all third trimester vaginal hemorrhages the mother needs, first of all, sufficient blood replacement. Therefore, at the first bleeding, which usually is not excessive, she should have an RH factor determination and should be typed and crossmatched for four pints of blood to be available on short notice. Only then is it safe to perform a sterile vaginal examination, and then only if all operative conditions are prepared for possible cesarean section.

Of the 57 patients with placenta previa seen at the Macon Hospital, 12 delivered without any specific therapy. Four were delivered by artificial rupture of the membranes alone; seven by artificial rupture of the membranes with administration of blood; five by

Presented at the 104th Annual Session of the Medical Association of Georgia, Macon, May 2-5, 1954.

From the Department of Obstetrics and Gynecology, Macon Hospital.

artificial rupture of the membranes with blood transfusions and intramuscular or intravenous pitocin; six with administration of blood alone; 22 by cesarean section. This gives us a cesarean section rate of 39 per cent in placenta previa which is comparable to the 40 per cent estimate of Shumann.⁹ Podalic versions may sometimes be a life-saving procedure for the mother; but we feel it should be reserved for the non-viable infant in marginal and lateral previa.

The fetal death rate during this period including neonatal deaths was 21.1 per cent which is somewhat higher than that of some other authors. Bailey² quotes 19.9 per cent over an 11 year period.

Premature separation of the normally implanted placenta is an accident of pregnancy for which several synonymous terms are currently in use: abruptio placenta, ablatio placenta and accidental hemorrhage. The terms denote a separation of the placenta from the placental site at any time before the birth of the child.¹⁰

The etiology of premature separation of the placenta is somewhat vague, but it is generally thought that it is associated with some type of toxemia. Dieckmann¹⁰ reports a 69 per cent incidence of toxemia in premature separation, Bartholomew¹⁰ 55 per cent, and Bysshe³ 24.4 per cent. We found only 14 patients out of 129 premature separations had toxemia, or 10.8 per cent. This relatively low toxemia rate is probably due to inadequate completion of charts. We accept the fact that there is an association with toxemia in premature separation but do not consider it a primary etiological factor. If it were a primary etiological factor, it would be expected that premature separation would often be associated with the most severe of toxemias, eclampsia, which is not the case in our series. Trauma seems to be an insignificant factor of less than one per cent in our series, although external version may cause an occasional premature separation. Torpin¹¹ has recently advanced the theory that abortions and premature separations of the placenta result from the placenta's being too deeply implanted. As the pregnancy progresses, the chorionic sac herniates out of the decidua capsularis pulling a portion of the placenta away from the uterine wall. This may create an abortion, placenta marginata, placenta circumvallata or, later in pregnancy, premature separation.

The wide variation in the incidence of premature separation of the placenta can be accounted for by the strictness of the criteria which one establishes for the diagnosis. We have encountered 129 cases of premature separation of the placenta out of 7,963 deliveries or 1.1 per cent which is markedly higher than that reported by the Chicago Lying-in-Hospital, 0.5 per cent, or by Bartholomew, 0.66 per cent¹⁰.

The potential seriousness of premature separation of the placenta makes its prompt diagnosis and immediate treatment mandatory. Diagnosis and treatment at the Macon Hospital depends upon the condition of the patient. While the diagnosis of severe premature separation with sudden pain, rigid uterus, shock, absence of the fetal heart tones and hemorrhage, affords little difficulty; that of mild or moderate premature separation presents more of a problem. In these cases, as in placenta previa, a lateral film is obtained. If the presenting part is well engaged and the patient is bleeding late in pregnancy, the diagnosis of premature separation is entertained. This is confirmed by sterile vaginal examination, with artificial rupture of the membranes at this time, if they are accessible. We seem to attach more importance to a good lateral film than other hospitals and clinics.

Treatment of our premature separations as in their diagnosis depends upon the severity of the separation. Since these patients frequently have severe hemorrhage, and since we have no means of knowing how much blood will be lost before the termination of the case, our first aim is replacement of blood lost and prevention and treatment of shock. As with placenta previa we cannot place too much emphasis on adequate blood replacement. Furthermore we should like to stress the use of oxygen along with blood in these patients; this is equally valuable for the fetus. As with placenta previa, the fulminating severe cases, while dangerous, offer the easiest problem since what must be done is obvious almost as soon as the patient is seen: the uterus must be emptied and bleeding controlled. We have found that bleeding can be controlled in practically all cases by artificial rupture of the membranes and application of a tight abdominal binder. Labor usually progresses rapidly, but if labor does not progress some have given intravenous or intramuscular pitocin in order to improve the character of the contractions. If given intravenously, five units is placed in 500 cc.'s of five per cent glucose in distilled water, and administration is regulated as to the intensity of the contractions. If the above measures fail and there is difficulty keeping up with the blood loss and maintaining blood pressure, cesarean section is indicated. Couvelaires uterus may be found at laparotomy, and if so a hysterectomy is carried out.

The group of patients who show a partial detachment with moderate bleeding and slight fetal distress present the greatest problem. Each one of these patients presents a different problem depending on the type of labor, condition of the baby, dilation of the cervix and blood loss of the mother, all of which must be considered in management of the case. In

this hospital the tendency is toward more conservative management. Most of our premature separations are treated by artificial rupture of the membranes, a tight abdominal binder, oxygen and blood replacement. Pitocin may or may not be used. If there is little or no labor with evidence of fetal distress and the above measures fail to produce a good labor, cesarean section may be done, keeping in mind the element of intrinsic fetal mortality which accompanies cesarean section.

Since at delivery these infants are usually depressed, we feel that they should be resuscitated immediately, preferably by direct administration of oxygen with the Torpin tracheal insufflator. These infants should never be allowed to become the least bit cyanotic, as usually they have already been subjected to a long period of sub-oxygenation. The uterus often fails to contract after delivery in premature separation. We have found that a Torpin automatic packer for packing the uterus highly successful in controlling post partum hemorrhage in our patients with premature separation.

Of the 129 cases of premature separation treated at the Macon Hospital, 74 received no treatment or non-specific treatment; 19 were treated by artificial rupture of the membranes alone; 13 by artificial rupture of the membranes with blood transfusions; 11 by artificial rupture of the membranes with blood transfusions and pitocin; nine by blood transfusions alone; and three by cesarean section. There were no maternal deaths during the period under discussion. The corrected total infant salvage rate 65.3 per cent including neonatal deaths and stillborns. In a series of 353 cases of premature separation from Charity Hospital¹ the corrected total infant salvage rate was 56.7 per cent.

The majority of patients who die from premature separation do so from exsanguination, while a few others die from renal and pituitary damage. In recent months much has been written about the defective clotting of blood associated with premature separation of the placenta. We had the opportunity to treat such a patient during the period under discussion. The etiology of this condition is not well understood, but the fundamental disturbance seems to be a reduction in the circulating fibrinogen.⁶ This case is presented as a matter of interest and to demonstrate what may occur in the more severe premature separations.

Case Report

A 36 year old, white woman gravida three, para two, was admitted to the Macon Hospital at five P. M., December 5, 1953, with relatively mild toxemia and clinical symptoms suggestive of complete separation of the placenta. The uterus was tetanic and measured 24 cms. There was a history of sudden pain 30 minutes before admission. Upon admission the blood pressure was 140/90, pulse rate 104, fetal heart tones 140. Blood was

typed and cross-matched and nasal oxygen started. She was taken to the delivery room, blood was started with a large needle, and the membranes were artificially ruptured under sterile conditions. The cervix was about two inches long, soft, and easily admitted one finger. The internal os was firm, and the breech was found to be presenting. Artificial rupture of the membranes was carried out with ease, and a large clot estimated at about 250 cc.'s was expressed from the vagina. After rupture of the membranes bleeding decreased somewhat, and she was returned to the labor room. The blood pressure and pulse was checked at 10 minute intervals and two and one-half hours after admission the blood pressure was 124/80 and pulse rate 90. A moderate amount of vaginal bleeding was still present. Five cc.'s of blood was obtained at this time and placed in a clean dry test tube for coagulation test.¹⁰ There was no clot formation, so arrangements were begun for obtaining fibrinogen. Three and one-half hours after admission the blood pressure dropped to 90/80 so a phlebotomy was done, and a large polyethylene tube was threaded into the vein. By 10:20, five hours and 10 minutes after her admission, she had received five pints of blood and 1000 cc.'s glucose five per cent. Blood pressure was maintained at 100/80 by pumping blood into the circulatory system through the polyethylene tube. Fibrinogen was unobtainable at this time, and we were having quite a bit of difficulty keeping up with her blood loss. There was no apparent labor and no fetal heart tones heard at this time, so it was decided to give whole fresh blood to try to establish clotting and to prepare the patient for a hysterectomy. 1000 cc.'s of whole blood was given by direct transfusion, and a 1000 cc.'s of fresh citrated blood was pumped into the arm at the same time. Five cc.'s of blood drawn upon completion of the direct transfusion showed fragmentary clot formation. Blood pressure varied from 80/40 to 100/60 during the time this blood was being pumped in. It was felt that this was the optimum time for surgery, and a supra-cervical hysterectomy was performed, the patient receiving 2000 cc.'s of fresh citrated blood during the procedure. Upon completion of this surgical procedure at 1:40 P. M. eight hours and 40 minutes had elapsed since admission. The patient had received 14 pints of blood, the blood pressure was 120/80, and the coagulation test at this time showed fragmentary clot formation at the end of five minutes. Due to the unfamiliarity of the laboratory with the technique, we were unable to obtain fibrinogen levels on admission of the patient. Seven hours and 20 minutes after surgery, she was given two grams of fibrinogen, after which fibrinogen plasma determination showed 200 mgm. per 100 cc.'s, normal being 300-600 mgm. per 100 cc.'s and her platelet count was 85,000. After the administration of two grams of fibrinogen, her post operative course was uneventful, except for the development of a mild phlebitis, and she was dismissed on the ninth post operative day.

We now follow the simple procedure of drawing five cc.'s of blood from all patients with premature separation of the placenta to detect faulty clot formation, and we now have the fibrinogen on hand to treat this deficiency.

Summary:

1) Fifty-seven cases of placenta previa and 129 cases of premature separation of the normally implanted placenta out of 7,963 deliveries over a 31 month period in the Macon City Hospital have been reviewed. This is an incidence of 0.7 per cent for placenta previa and 1.1 per cent for premature separation.

2) The incidence of toxemia of pregnancy occurred in only 10.8 per cent of the cases of premature separation.

3) There were no maternal deaths from either placenta previa or premature separation.

4) In the patients with placenta previa the corrected fetal death rate was 21.1 per cent. In those with premature separation the corrected fetal death rate was 34.7 per cent.

5) The treatment of choice in the patients with

placenta previa indicates a tendency toward operative management in that the incidence of cesarean section in this series was 39 per cent.

6) A more conservative method of treatment was observed in the patients with premature separation, consisting of blood replacement, artificial rupture of the membranes and application of a tight abdominal binder. Pitocin was employed frequently to improve character of contractions in patients with inadequate labor.

7) The use of oxygen is stressed for the benefit of the mother as well as the fetus.

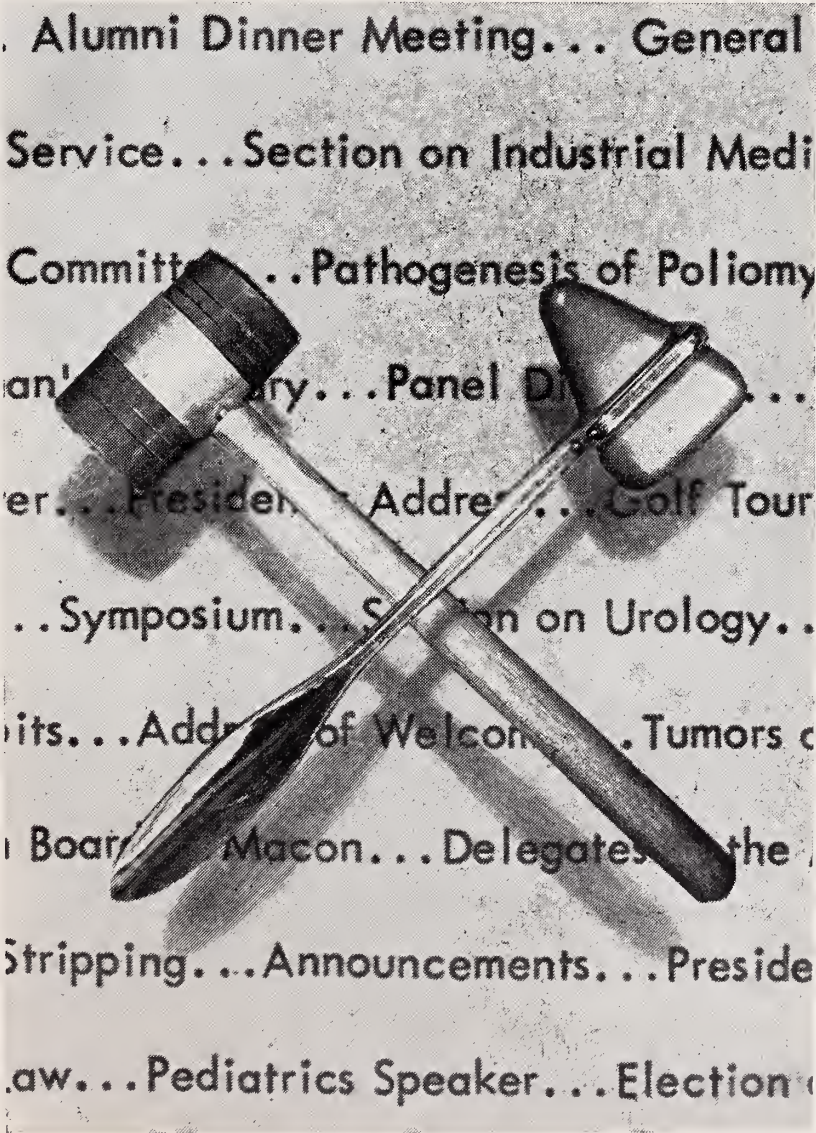
8) A case of afibrinogenemia occurring in premature separation is presented and discussed as to diagnosis and treatment.

University Hospital

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AUGUSTA



MAY 1 thru 4

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Chambers, William R., 101 Third St., N. E., Atlanta, Ga. "Headache as the First and Only Sign of Basilar Impression", J. Bone & Joint Surg. 37-A:189-192 (Jan.) 1955.

A recognition of platybasia in its early stages is so important that attention to the early signs is most desirable. Among these is occipital headache. Prolonged interference with the nervous function at the occipito-atlantal junction may result in syringomyelia or hydro-myelia, and permanent impairment of function is to be expected as well much greater operative risk. Differential diagnosis of multiple sclerosis, amyotrophic lateral sclerosis and tumor of the posterior fossa is to be made. As has been previously described, the outstanding and only complaint may be headache aggravated by cough, sneeze and extension of the head. It may be accompanied only by weakness and dizziness. The headache may be completely relieved by decompression of the foramen magnum with section of the sensory root at C-2 and C-3 bilaterally. Future neurological complications seem also to be prevented by this procedure.

Kanthak, Frank F.; Hamm, William G.; and Yarn, Charles P., Jr., 710 Peachtree St., N. E., Atlanta, Ga. "Fibrous Dysplasia of the Facial Bones", Plast. & Reconstruct. Surg. 15:41-55 (Jan.) 1955.

Eight cases of fibrous dysplasia are presented which are studied from the standpoint of etiology and therapy. Fibrous dysplasia of the facial bones is frequently polyostotic in nature, in that more than one facial bone is involved. The differentiation of fibrous dysplasia from the older termed ossifying fibroma or fibrous osteoma may indeed be difficult. It is not clear whether this represents a tumor or, as Lichtenstein and Jaffe mention, a failure of development of the mesenchyme in otherwise normal bone.

It is felt that treatment of these lesions should be directed toward removing the cosmetically or functionally interfering portion of the area and with restoration of contour and function; the patient should be followed for a significantly long period to see that recurrence is not present. X-ray therapy seems to be indicated in either reducing recurrences or in actually shrinking the size of the lesion. Malignancy occurring in fibrous dysplasia of membranous bones has not been reported, but a case of sarcoma arising in the long bones affected with fibrous dysplasia has been reported. In view of the benign nature of fibrous dysplasia of the facial bones, we seldom feel that massive resection of the bones is justified.

Bennett, Robert L., Warm Springs, Ga. "Classification and Treatment of Early Lateral Deviations of the Spine Following Acute Anterior Poliomyelitis", Arch. Phys. Med. & Rehab. 36:9-17 (Jan.) 1955.

Of all skeletal deformities following acute anterior poliomyelitis, scoliosis constitutes the most serious threat to functional activity and to life itself. Four basic forms of early lateral deviation can be seen by clinical and X-ray visualization. In this discussion these curves have been designated as Types I, II, III and IV. This is an arbitrary listing of the curves beginning in the lumbosacral region and extending upward to the high dorsal region. Specific care is not discussed. Important points in the early care are as follows:

Conservative methods of care are incapable of correcting structural scoliosis following acute anterior poliomyelitis. Prevention of significant structural scoliosis is possible, but can be achieved only through early recognition and control of all those factors present in the individual patient that could cause persistent faulty alignment of the spine.

Asymmetrical tightness or excessive asymmetrical mobility of the spine is the earliest sign of incipient scoliosis.

Specific stretching of contractures influencing spinal alignment must be started early.

Early anteroposterior mobilization of spine is dangerous unless the trunk musculature is of good strength.

No activity in sitting or standing position should be permitted unless good alignment of the spine can be maintained.

Anteroposterior visualization by X-ray of the patient in the

sitting position should be obtained as soon after the acute stage as possible, and should be repeated every three to four months until child is fully grown.

Hobby, A. Worth, 490 Peachtree St., N. E., Atlanta, Ga. "Cough, Its Pathology and Management," Am. J. Surg. 89:285-293 (Feb.) 1955.

Two to three million persons are suffering from chronic broncho-pulmonary disease. The causes and pathology vary and must be determined in each case in the same way that management must be individualized. Pre and postoperative care is essential as a prophylactic measure. Drug therapy requires an intimate knowledge of the pharmacology of each and every drug and their combination. The newer drugs are discussed with the older drugs, exploding some old theories and bringing out later results. Gases and aerosols are effective only if and when properly used in combination with newer apparatus such as positive breathing insufflators and in such manner as to prevent "rain out" in the lungs. Radiation therapy and "teaching the patient" are little used important adjuncts to proper management of cough. This paper emphasizes the necessity of knowing the details about every kind of cough and every method of management to give the patient the most efficient benefit. Cough is a symptom taken too lightly by the average physician, who usually prescribes the cough remedy that has been described by the last "detail man".

King Richard, 1293 Peachtree St., N. E., Atlanta, Ga. "Achalasia of the Esophagus", Am. Surgeon 21:39-44 (Jan.) 1955.

Achalasia of the esophagus may be defined as a non-organic stenosis of lower three to six cms. of the esophagus with dilatation and hypertrophy above. The most appealing theory in regard to etiology is the one first suggested by Hurst in 1914, when he stated that the most probable cause of achalasia was the progressive degeneration of Auerbach's plexus.

The cardinal clinical symptoms are dysphagia, regurgitation and substernal pain. Fluoroscopic and roentgenographic examinations after a barium meal are the most important diagnostic aids. Esophagoscopy should be done to rule out the possibility of carcinoma of the esophagus or cardia. Pneumonitis, bronchiectasis and lung abscess may develop as a result of nocturnal regurgitation.

In regard to treatment, the consensus seems to favor hydrostatic dilatation. The author believes, however, that more cases will be treated by surgical intervention initially before dilatation is done because the mortality rate is little if any higher.

Heller's technique is the most appealing surgical procedure at the present. The incision in the stomach and esophagus down to the mucosa must be of adequate length in order to obtain good results with this technique. Seven successful cases are reported varying in ages from nine months to 72 years.

Chambers, William R., 101 Third St., N. E., Atlanta, Ga. "The Headache of Chronic Subdural Hematoma", Am. Pract. & Dig. Treatment 6:84-86 (Jan.) 1955.

A study of the headache of chronic subdural hematoma emphasizes what has been said before that subdural hematoma may simulate almost anything. Surprisingly enough the headache was found to start in the occipital area almost as often as over the vertex even though the subdural was supratentorial. In some instances it was accompanied by trance-like states suggestive of petit-mal epilepsy. In other instances personality deviations were the principal accompanying signs. The spinal fluid pressure was as likely as not to be within normal limits, and in a few instances novocain injection of the scalp in the area of the greatest intensity of pain stopped the headache temporarily.

The outstanding characteristics appeared to be that a patient who has had a moderate head injury, as shown by no period of unconsciousness or only a short duration of such, and who has had a headache lasting usually for several weeks which has become progressively more severe and is accompanied by somnolence, mental dullness or nausea, is to be suspected of subdural hematoma.



doctor placement page

NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

AVAILABLE PHYSICIANS

Berry, Bradley, D., M.D., Whitfield, Mississippi—Age 35; married; Methodist; graduate Jefferson Medical College, Philadelphia, Pennsylvania, 1953; completed internship; interested in general practice in Georgia in community under 10,000; available one month after notified.

Buckner, Leslie, M., M.D., 937 Carew Tower, Cincinnati 2, Ohio—Age 54; married; Methodist; graduate University of Louisville, 1927; residency Bethesda Hospital, Cincinnati, Ohio; Association in Ob-Gyn with FACS; inactive reserve; has a Georgia license and could be available within 2-3 months.

Bryant, Milton F., Jr., M.D., 8166 USA Hospital, APO 547, San Francisco, California—Age 29; married; Protestant; graduate University of Michigan, 1948; residency University of Michigan Hospital; certified by American Board of Surgery; in service at present; specialty general surgery; available August 1955.

Clark, James H., M.D., Butler, Alabama—Age 32; married; Baptist; graduate University of Tennessee, 1946; recently in practice; desires location with better hospital facilities; interested in general practice.

Collins, Douglas, M.D., 172 Riverside Park, Iowa City, Iowa—Age 33; married; Methodist; graduate University of Alabama School of Medicine, 1951; residency State University of Iowa Hospital; specialty Ob-Gyn; available July 1, 1955.

German, Walter A., Jr., M.D., 1934 Shoup Court, Apt. 2, Decatur, Georgia—Age 30; married; Methodist; graduate Washington University School of Medicine, 1951; residency Grady Memorial Hospital; specialty ob-gyn; desires associateship; available July 1, 1955.

Gillikin, Wm. Vernon, M.D., Columbus City Hospital, Columbus, Georgia—Age 30; married; Baptist; graduate Bowman Gray School of Medicine, 1954; interested in general practice in clinic; available July 1955; interning at present and interested in ob-gyn but if could find something interesting would consider general practice.

Gorman, John B., M.D., Capt. USAF (MC) AME, 6110th USAF Hospital, APO 1054, San Francisco, California—Particularly interested in general practice with some surgery or possible industrial medicine; graduate University of Virginia, 1951; rotating internship Charity Hospital 1951-52; practiced in Arizona less than a year before entering Air Force; licensed to practice in Virginia; served during past year as chief of Otolaryngology, and Chief of Aviation Medicine at General Hospital, Nagoya, Japan.

Hanberry, Richard L., Jr., M.D., 177 First Avenue, S. E., Atlanta, Georgia—Age 32; married; Episcopalian; graduate Medical College of Georgia, 1951; residency Grady Memorial Hospital, Atlanta; specialty Ob-Gyn; available August 1, 1955.

Howard, Hugh David, M.D., 1206 Roosevelt Road, Broadway, Illinois—Age 33; married; Protestant; graduate Northwestern University, 1947; residency VA Hospital, Hines, Illinois; completed three

year approved residency in medicine; now Board eligible; presently in practice with VA, would like to go into private practice; Priority IV; specialty internal medicine; prefers clinic, or as assistant or associate; available anytime.

Hunter, I. H., M.D., 204 East Hill Avenue, Valdosta, Georgia—Age 73; married; Missionary Baptist; graduate Grant University, Chattanooga, Tennessee, 1903; interested in general practice; specialty pediatrics; prefers community of 1,000; will accept good position with clinic; been in active practice for 50 years.

Jerius, Diab H., M.D., 18218 Appline Street, Detroit, Michigan—Age 51; single; Protestant; graduate Lausanne University; Switzerland, 1935; residency Sinai Hospital, Detroit; interested in general practice in Georgia as an associate; available immediately.

Johnson, Richard Chadwick, M.D., P. O. Box 304, Sand Springs, Oklahoma—Age 34; married; Presbyterian; graduate Yale University, 1945; residency Hillcrest Memorial Hospital, Tulsa, Oklahoma, one year surgery—University of Virginia Hospital, Charlottesville, Virginia, one year medicine—eight months residency credit in medicine USN; six years practice of internal medicine; presently in practice, would like a larger community not predominantly industrial and one that has more cultural advantages for family; Priority IV; specialty internal medicine; available in about 60 days following notice; will not accept any "practices for sale."

MacKavanaugh, James L., M.D., 160 Marion Avenue, Merrick, L. I., New York—Age 45; married; Roman Catholic; graduate Georgetown University Medical School, 1934; presently in general practice; wishes to relocate; Priority III; interested in general practice in Georgia, size not too important; available within two to three months after location is selected.

McConnell, Ben H., M.D., Box 664, Beltsville, Maryland—Age 36; married; Episcopal; graduate Georgetown University, 1950; interested in general practice as student health physician with any school, college or university; available at once.

Marder, Leon, M.D., 323 East Chestnut Street, Louisville 2, Kentucky—Age 32; married; Hebrew; graduate University of Oklahoma, 1949; USAF reserve; residency St. Johns General and Michael Reese Hospitals; specialty internal medicine; wishes to associate or share office space with another physician or enter private practice in a community where vacancies exist; available July 1, 1955.

Matousek, Wm. Chas., M.D., 9766 TU, Camp Detrick, Maryland—Age 31; married; Protestant; graduate University of Illinois, 1948; residency Walter Reed Army Hospital; passed Part I of the American Board of Internal Medicine; take Part II in May; available July 1955.

Mohr, Alton J., M.D., Tremonton, Utah—Age 40; desires rural area where one may raise a family in pleasant surroundings; preferably near a hospital; served in Army during World War II; been practicing in Utah since 1945; graduate Northwestern University; 10 years as a general practitioner; available immediately.

Patterson, James L., M.D., 412 National Bank Building, Logan, West Virginia—

Age 55; married; Presbyterian; graduate Medical College of Virginia, 1928; residency C & O Hospital, Huntington, West Virginia; presently in practice, would like climatic change; interested in industrial medicine in Georgia.

Peake, Charles O., M.D., 884½ 9th Avenue S.E., Rochester, Minnesota—Age 27; married; graduate University of Pennsylvania 1951; internship Evanston Hospital; residency Mayo Foundation; Priority IV; specialty ob-gyn; prefers community of 50,000 or over; interested in locating in Georgia, particularly Atlanta, in clinic, as assistant or associate; available July 1, 1955.

Richardson, B. A., M.D., 544 West 2nd Street, Lexington, Kentucky—Age 28; married; Methodist; graduate University of Tennessee, 1954; interested in general practice in Georgia; available August 1, 1955.

Scruggs, W. H., M.D., Bryson City, North Carolina—Age 65; limited general practice; licensed in Georgia; married; Baptist; graduate University of Maryland, 1913; prefers small town with hospital; available anytime during next three months.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland—Age 30; married; Roman Catholic; graduate Georgetown University 1948; residency USN Hospital, Bethesda, Maryland; Priority IV; specialty internal medicine; prefers community in Georgia of 20,000 to 30,000; available June 1955.

Shannon, Lloyd W., M.D., 1234 Henleaze Avenue, Moose Jaw, Saskatchewan, Canada—Age 31; married; Presbyterian; graduate University of Manitoba, 1947; presently in practice, wishes to relocate because medicine is becoming greatly socialized in Saskatchewan; specialty general surgery; industrial assistant or associate, would consider clinic; available February or March 1955.

Sharp, Thomas B., Jr., M.D., 1530 Shoup Court, Decatur, Georgia—Age 28; married; Protestant; graduate Emory University, 1950; residency Lawson VA Hospital; Grady Memorial Hospital; military requirements fulfilled; specialty internal medicine; clinic preferred; available July 1, 1955.

Watson, Alfred Lawrence, M.D., 1415 Titus Road, Memphis 11, Tennessee—Age 29; married; Methodist; graduate Vanderbilt University School of Medicine, 1949; residency Grady Hospital and Kennedy VA Hospital, Tennessee; Priority IV; specialty internal medicine; available July 1, 1955.

Wilson, James Woodfin, Jr., M.D., Essex County Sanatorium, Verona, New Jersey—Age 32; married; graduate Louisiana State University, 1948; residency Confederate Memorial Medical Center (internal medicine) one year; Essex County Sanatorium (pulmonary disease, at present); Priority IV; interested in general practice in clinic with emphasis on internal medicine, as assistant or associate or industrial; available about July 1, 1955.

Wimberly, John A., M.D., 909 North Broadway, Lexington, Kentucky—Age 29; married; Methodist; graduate University of Louisville, 1952; residency St. Joseph Hospital; will finish one year general surgery July 1, 1955; Priority IV; available July 1, 1955.

AVAILABLE LOCATIONS

Arlington, Georgia (Calhoun County)—Population 1,382. In need of doctor-surgeon for practice in new excellently equipped 16-bed hospital, located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia.

Broxton, Georgia (Coffee County)—Population 3,500—Doctors clinic available; also home available; 60 room county hospital at Douglas; seven room doctors building; no physician in area; physician will have more work than he can do. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia.

Dillard, Georgia (Rabun County)—Population 2,500. Doctor's office to be furnished rent free for one year; would rent five or six room house, fully equipped kitchen, county hospital at Clayton; drug store and pharmacist; good schools; doctor would be welcome right now; late doctor had an excellent practice; other benefits considered in a short time; active church groups and community club that would be happy to assist doctor. Contact: Mrs. L. Neville, Dillard, Georgia.

Edison, Georgia (Calhoun County)—Population 1,245. Two physicians in area; Hill-Burton Hospital (1 mi.); one clinic local with 10 beds, x-ray, lab equipment,

operating room with instruments; rental \$75.00 (maximum \$100.00) per month; two excellent drug stores; housing available for rent at \$30-\$40; good elementary and high schools; five churches; great need for a physician in this community. Contact: Dr. J. S. Beard, Edison, Georgia.

Hampton, Georgia (Henry County)—Population 1,000—No doctor in Hampton, nearest 10 miles away; hospital in Griffin; office space, housing available; contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia.

Marietta, Georgia (Cobb County)—Population 10,000. Interested in Negro physician to replace present physician who is going into Armed Forces in approximately six months. Contact: Mr. M. L. Wear, Administrator, Kennestone Hospital, Marietta, Georgia.

Smithville, Georgia (Lee County)—Population 700—No physician in area; home in Leesburg, office downtown rent free; completely equipped office of two rooms and connecting lavatory with outlets for sterilizers, etc., attached. All private practice available. Contact: Mr. Charles A. Dean, Smithville Drug Store, Smithville, Georgia.

Tifton, Georgia (Tift County)—Population 12,000—Local hospital available; housing available at reasonable cost; especially need EENT man. Contact Mrs. Agnew Andrews, Tifton, Georgia.

Unadilla, Georgia (Dooly County)—Population 1,200—Dooly County Hospital owned and operated by the people of the county; office space available or will build small clinic and let doctor rent or buy. Housing will be provided rent reasonable or can get house built to suit. They guarantee a good doctor will do well; one physician in area, age 75. Contact: Mr. E. H. Conner, Unadilla, Georgia.

Winder, Georgia (Barrow County)—Population 6,000. Eight physicians in area; four active, two part time and two inactive; 40 bed Hill-Burton Hospital in city limits—completely equipped; office space available; three active drug stores; interested in obtaining services of two or three young physicians who want to do general practice; feel that area has much to offer with a good sound economy, ideal location, adequate hospital facilities and a crying need for well trained interested men; contact, by phone, mail or in person for any further information, Dr. C. B. Skelton, Peoples Bank Bldg., Winder. (Office Phone 3851).

Woodbine, Georgia (Camden County)—Population 1,000. Small, fully equipped office and clinic available; ample office space, delivery room, laboratory (inc. x-ray), nursery, wards, private rooms; five room wooden dwelling adjoins hospital available at \$35.00 mo.; one other doctor in Woodbine, doctor is needed now. Contact: Dr. S. C. Atkinson, Waverley, Ga.

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MAG Council Meeting

March 12-13, 1955, Augusta

THE FINAL MEETING of the Council of the Medical Association of Georgia for 1954-55 was called to order at 8:30 p. m. at the Bon Air Hotel, Augusta, by Chairman Harry L. Cheves, Union Point.

Present were the following Councilors: Lee Howard, Savannah, 1st District; W. G. Elliott, Cuthbert, 3rd District; J. W. Chambers, LaGrange, 4th District; J. G. McDaniel, Atlanta, 5th District; Henry H. Tift, Macon, 6th District; D. Lloyd Wood, Dalton, 7th District; Neal F. Yeomans, Waycross, 8th District; W. Bruce Schaefer, Toccoa, 9th District; Harry L. Cheves, Union Point, 10th District. Absent was George Dillinger, Thomasville, 2nd District. (Dr. Tift will fill the unexpired term of President-Elect Allen.)

Vice-Councilors present included Clarence B. Palmer, Covington, 4th District; Charles Andrews, Canton, 9th District; and J. G. McDaniel, Atlanta, 5th District, who acted as Councilor in the absence of Mark S. Dougherty, Jr., Atlanta.

Officers present were Peter B. Wright, Augusta, President; H. Dawson Allen, Milledgeville, President-Elect; and David Henry Poer, Atlanta, Secretary-Treasurer.

Also present were Thomas W. Goodwin, Augusta, Chairman of the Local Arrangements Committee for the 1955 Annual Session; Eustace A. Allen, Atlanta, and Spencer Kirkland, Atlanta, Delegates to the AMA; W. L. Sheppard, Augusta, and the Messrs. John F. Kiser and Milton D. Krueger, MAG Headquarters Office.

Minutes of the December 11-12th meeting of Council were read by the Executive Secretary and minutes of the February 4th telephone conference of the Executive Committee of Council were read by the Executive Secretary.

On a motion (McDaniel-Tift) the minutes of these meetings were adopted.

The first item of business was a report of the Constitution and By-Laws Committee by J. W. Chambers, Chairman. Dr. Chambers reviewed the work of the Constitution and By-Laws Committee during the year and noted major changes which have been proposed in the Constitution and By-Laws. Those changes affected the following: (1) composition of House of Delegates, (2) duties and composition of Council, (3) successor to the president, (4) membership changes to conform with AMA, (5) times and places for meetings of House of Delegates, (6)

terms of component society delegates to House of Delegates, (7) separation of offices of secretary and treasurer, (8) composition and duties of Executive Committee, (9) duties of the Auditing and Appropriations Committee, (10) election and duties of officers and (11) standing committees. These changes will be published in the April issue of the *Journal* and will come before the House of Delegates in May in Augusta.

Dr. Chambers recommended that a special reference committee of the House of Delegates be appointed to study the report of the Constitution and By-Laws Committee so that they will have ample time to go over all of the changes that have been proposed at the House of Delegates meeting.

On a motion (Elliott-Wood) a rising vote of thanks to Dr. Chambers, his committee and the headquarters office, was given by members of Council.

The next item of business concerned reports.

Dr. W. L. Sheppard, pathologist, Medical College of Georgia, representing Dr. Edgar Pund, President of the Medical College of Georgia, presented a report on a meeting of the Council on Medical Education of the American Medical Association held recently in Chicago.

Dr. Sheppard made three points: he pointed out that medical schools should teach more legal medicine as recommended at the meeting in Chicago; it was pointed out at the meeting in Chicago that 25 per cent of all house staffs, exclusive of scholarships, are alien physicians; state institutions are expanding as compared to endowed institutions and this problem has become controversial in several states.

Dr. Goodwin presented a report of the Local Arrangements Committee for the 1955 Annual Session to be held in Augusta.

The Executive Secretary read the following: Report of the 51st Congress on Medical Education and Licensure, Chicago, February 5-8, 1955, by Dean R. Hugh Wood, Emory University, Chairman of the MAG Committee on Medical Education; Report by George T. Nicholson, Cornelia, Chairman of the Rural Health Committee, on two Rural Health meetings, one in Miami, on November 29, 1954, sponsored by the AMA Council on Rural Health, and another on February 23 in Milwaukee, the National Conference on Rural Health; Report of a Joint Conference of Chairmen of State Medical Society Committees on Industrial Health by Duncan Shepard, Atlanta, Chairman of the MAG Industrial Health Committee; Report of a meeting on Veterans Affairs sponsored by the AMA on February 19 in Chicago by Hartwell Joiner, Gainesville, Chairman of the MAG Veterans Affairs Committee; and Report by J. Harry Lange, Atlanta, of a special committee of representatives of the MAG who met with members

of the State Board of Health in regard to the provisional approval of the administration of the Salk polio vaccine to first and second graders in April.

On a motion (Chambers-Yeomans) provisional approval by Council was given to the Salk polio vaccine field trials.

A report on plans for the selection of a recipient for the Hardman Award were discussed by Mr. Krueger, Executive Secretary. He said that nine names have been submitted in nomination for the Hardman Award.

On a motion (Elliott-Poer) a special committee of Council was appointed to study the nominations and to recommend three names at the next meeting of Council to be held at the Annual Session in Augusta.

Dr. Cheves appointed Henry H. Tift, Macon, chairman of the special committee and Neal Yeomans, Waycross, and D. Lloyd Wood, Dalton, as members of the committee.

Council instructed the Executive Secretary to write Mr. Lamartine Hardman, Jr., of Commerce, expressing thanks for his interest in the Award.

Professional conduct problems in the Georgia Medical Society and the Fulton County Medical Society were discussed by Dr. Howard, Dr. McDaniel and others.

There being no further business the meeting was recessed until 9:30 a. m. the following morning.

The recessed meeting of Council was called to order by Vice-Chairman W. G. Elliott, Cuthbert, at 9:30 a. m. in the Chinese Room at the Bon Air Hotel, Augusta, March 13, 1955.

Those present for the Sunday morning meeting who were not present on Saturday night were Milford B. Hatcher, Macon, 2nd Vice-President; Grady N. Coker, Canton, Chairman of the Committee on Legislation; J. L. Chandler, Augusta, Chairman of the AMEF Committee; David R. Thomas, Jr., Augusta, Chairman of the Insurance Board; Ralph Fowler, Marietta, 7th District Vice-Councilor and R. W. Hanckel, Charleston, South Carolina, a member of the Insurance Committee of the South Carolina Medical Association.

The invocation was read by Mr. Krueger, Executive Secretary.

The first order of business was the report of the AMEF Committee by J. L. Chandler, Chairman.

Dr. Chandler pointed out that only 47 doctors in the State, during 1954, had contributed \$2,500, while the two medical schools in the State had received \$48,000 from the AMEF.

The matter of voluntary assessments of the members was discussed by Drs. Dawson Allen, Poer, Chandler and Tift.

On a motion (Schaefer-Yeomans) it was voted to refer the matter of an assessment of \$5.00 for the AMEF to the House of Delegates at the meeting in May in Augusta.

The next item of business was the report of the Committee on Legislation by Grady N. Coker, Chairman. Dr. Coker discussed the recent session of the Georgia legislature and reported on approximately 25 bills which were of interest to the medical profession.

He pointed out that some 10 bills will be introduced by the committee at the next session in January 1956. These bills would relate to indigent hospitalization, oral prescriptions to conform to federal laws, rabies inoculations, mental health laws and other matters. Dr. Coker expressed thanks for the assistance given his committee by the headquarters office, particularly Mr. John Kiser, during the session of the Legislature. Council then voted its thanks to Dr. Coker for his fine work and to the other members of the committee.

Mr. Krueger presented a resolution relating to the operation of the Eugene Talmadge Memorial Hospital in Augusta which was unanimously adopted by the Board of Regents at its meeting on March 9, 1955.

On a motion (Allen-Poer) it was voted that Council accept as information this resolution and refer it to the Richmond County Medical Society for action before the Council or the House of Delegates takes any action on this matter.

It was suggested that a special note in the Delegates Handbook be made to point out that this resolution will be included in the report of the Study Committee on the Eugene Talmadge Memorial Hospital.

The next item of business was the expansion of the headquarters office to include a new room which can be used as office or conference room. Dr. Poer explained the new office setup.

The next item of business was a brief report by Mr. Krueger on plans for the 1956 Annual Session to be held in Atlanta.

The next item of business was the discussion of professional liability insurance. David R. Thomas, Augusta, Chairman of the Insurance Board, reported on progress of the committee. Dr. Poer discussed the possibility of arranging a regional conference of Southern States to be sponsored by the MAG to discuss professional liability insurance. R. W. Hanckel, from Charleston, South Carolina, reported on the work of the Insurance Committee of the South Carolina Medical Association.

On a motion (Hatcher-Poer) the Insurance Committee was authorized to invite representatives of adjoining states to a joint conference on professional

liability insurance. Council also authorized Fred Simonton, who is attending the American Academy of General Practice meeting in Los Angeles, to visit with officials of the county medical society in San Francisco to report back their findings on a group policy of professional liability insurance.

Then on a motion (Poer-Thomas), it was voted to call in other states to attend the April 3 meeting of the Insurance Board and to also invite Dr. Simonton to attend this meeting.

Eustace Allen, Atlanta, Delegate to the AMA, then expressed his thanks to Council for its resolution endorsing his candidacy for the office of vice-president of the American Medical Association.

The next item of business was the report of the Secretary-Treasurer by David Henry Poer, Atlanta.

Dr. Poer reported on the financial status of the Association and stated that a bank balance of \$45,-438.38 was on record as of Friday, March 11, 1955.

Dr. Poer discussed items that had come up which were not accounted for in the budget.

Dr. Poer reported that the Georgia Academy of General Practice recently voted to contribute \$200 annually for postage and telephone use by the Academy.

Dr. Poer then discussed the organization of the Association and the relationship between the Council, the MAG Secretary and the Executive Secretary. Following his talk, the same matter was also discussed by Mr. Krueger and other members of Council.

Council voted thanks to Dr. and Mrs. Wright for their hospitality.

There being no further business, the meeting adjourned to a luncheon at the residence of Peter B. Wright.

Industrial Health Conference

January 24, 1955, Washington, D. C.

On Monday, January 24th the joint Conference of Chairmen of State Medical Society Committees on Industrial Health was held at the Shoreham Hotel in Washington, D. C. Thirty states were represented by their state chairmen. They were given a review of the present status of implant medical services throughout American industry and the cost of compensation insurance and of vocational rehabilitation; these talks were by various members of the Public Health Service. Following this there was an open discussion by all the state chairmen outlining the work which they were doing and bringing up any problems which they had, at which time comments were asked from the other state committee chairmen. The afternoon was spent in a guided tour of the Clinical Center of the United States Public Health Service at Bethesda, Maryland; in addition to touring the center, the chairmen were told about the

various research projects in progress, particularly those having to do with industrial health.

The Fifteenth Annual Congress on Industrial Health was held on Tuesday, January 25th, and Wednesday, January 26th. The main theme of the congress this year was the care of the total man in relation to his environment; the various presentations were slanted to give those attending an overall picture of the problems of health in an industrial society, and no emphasis at all was put on the curative side of illness and injury. In addition, there was a day-long discussion of the present status of Workmen's Compensation laws. This was participated in by the medical profession, representatives of labor, a representative from the American Bar Association and a representative from the Committee of Trauma of the American College of Surgeons. Many of the inconsistencies of the Workmen's Compensation Act were pointed out, and many interesting suggestions were given in an effort to formulate thinking in regard to revising the present Workmen's Compensation Act. Concrete suggestions were advanced by the Committee on Trauma of the American College of Surgeons as to how such a law could be administered more rapidly and more satisfactorily. Both meetings were most informative and helpful.

Report of Constitution and By-Laws Committee

J. W. Chambers, Chairman

This committee has met several times during the year and the attached report represents the work done by the committee at its various meetings. In addition to the members of the committee as appointed, the president, Dr. Peter B. Wright, and the president-elect, Dr. H. Dawson Allen, gave generously of their time and attended the various meetings.

All recommendations received by the committee have been given thoughtful consideration and have been filed in the working notes of the committee.

The committee would like to express its appreciation to Mr. John Kiser and Mr. Milton Krueger for their fine cooperation in providing secretarial and editing assistance throughout the year.

The committee has attempted to completely re-write the Constitution and By-Laws, wherever possible, to make it agree with that of the American Medical Association as adapted to the needs of our own Association, always attempting to strengthen the organizational structure of the Medical Association of Georgia and to allow it to function more smoothly and efficiently.

We respectfully submit the following report for your consideration:

Now Reads:

CONSTITUTION ARTICLE I.

Name of the Association

The name of this organization is The Medical Association of Georgia.

Will Read:

CONSTITUTION ARTICLE I.

Name of the Association

The name of this organization is The Medical Association of Georgia. It is an association of its component county medical societies.

ARTICLE II.

Purposes of the Association

The purposes of the Association shall be to advance the science of medicine; to promote the interests and uphold the honor of the profession of medicine; to acquire, utilize and disseminate information relative to all diseases and degenerative processes affecting mankind to the end that the people of Georgia may have the most adequate medical care possible; to promote public health, and to foster cordial relations between the members of the medical profession and the general public.

Will Read:

ARTICLE II.

Purposes of the Association

The purposes of the Association are to promote the science and art of medicine and the betterment of public health.

Now Reads:

ARTICLE III.

Component Societies

Component societies are those county medical societies which hold charters from the Association or which may hereafter be organized and chartered by the House of Delegates of the Association.

Will Read:

ARTICLE III.

Component Societies

Component societies are those county medical societies which hold charters from the Association or which may hereafter be organized and chartered by the House of Delegates of the Association to form the Medical Association of Georgia.

Now Reads:

ARTICLE IV.

Composition of the Association

Sec. 1. The Association is composed of members and delegates.
Sec. 2. Members. The members of the Association are the members of the component county medical societies.
Sec. 3. Delegates. Delegates are those members elected in accordance with this Constitution and By-Laws to represent their component county medical societies in the House of Delegates of the Association.

Will Read:

ARTICLE IV.

Membership

SEC. 1. MEMBERS. The members of the Association are the members of the component county medical societies. The Association is composed of Active, Service, Associate and Honorary members as provided for in the By-Laws. Other types of membership may be provided for in the By-Laws.

SEC. 2. TENURE OF MEMBERSHIP. A member shall retain his membership as long as he complies with the provisions of the Constitution and By-Laws and with the Principles of Medical Ethics of the American Medical Association.

Now Reads:

ARTICLE V.

House of Delegates

Sec. 1. Powers. The legislative body of the Association is the House of Delegates and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.

Sec. 2. Composition. The House of Delegates is composed of (1) delegates elected by the component county medical societies, (2) the officers and past presidents of the Association and (3) the delegates to the American Medical Association.

Will Read:

ARTICLE V.

House of Delegates

SEC. 1. COMPOSITION. The House of Delegates is composed of delegates selected by the component county medical societies as provided in the By-Laws. The general officers, the Past Presidents and Past Councilors of the Association, the Treasurer, Editor of the JOURNAL, Delegates to the AMA, the Executive Secretary and Chairmen of Standing Committees shall be *ex-officio* members of the House of Delegates without the right to vote.

SEC. 2. DUTIES. The House of Delegates is the legislative body

of the Association, and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.

Now Reads:

ARTICLE VI.

Council

Sec. 1. The Council shall be the Board of Trustees and the Board of Censors of the Association. It shall carry out the mandates and policies as determined by the House of Delegates. The Council shall have full authority and power of the House of Delegates between sessions of that body. The Council shall have charge of all the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

Sec. 2. The Council shall consist of the President, the President-Elect, the Secretary-Treasurer and one Councilor from each Congressional District in the State of Georgia.

Will Read:

ARTICLE VI.

Council

SEC. 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past-President, two Vice-Presidents, the Secretary, the Speaker of the House of Delegates, and 10 Councilors as provided for in the By-Laws. The Treasurer, Editor of the JOURNAL, Executive Secretary and Delegates to the AMA shall be *ex-officio* members of Council without the right to vote. Vice-Councilors shall be *ex-officio* members except in the absence of their respective Councilors as provided for in the By-Laws. The Vice Speaker shall be an *ex-officio* member except in the absence of the Speaker as provided in the By-Laws.

SEC. 2. DUTIES. The Council is the Board of Trustees and the Board of Censors of the Association. It carries out the mandates and policies as determined by the House of Delegates. The Council has full authority and power of the House of Delegates between sessions of that body. The Council has charge of all the property and financial affairs of the Association and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

Now Reads:

ARTICLE VII.

Sessions and Meetings

Sec. 1. Annual Session. The Association shall hold an annual session during which there shall be general meetings open to all registered members, delegates and guests.

Sec. 2. Time and Place. The time and place for holding each annual session shall be fixed by the Council.

Sec. 3. Special Meetings. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Council, twenty delegates or upon written petition of one-fourth of the members of the Association.

Will Read:

ARTICLE VII.

Meetings

SEC. 1. ANNUAL SESSION. The Association shall hold an Annual Session at a time and place fixed by Council.

SEC. 2. HOUSE OF DELEGATES. The House of Delegates shall meet during the Annual Session and in interim sessions as may be determined by Council.

SEC. 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of Council, 20 delegates or upon written petition of one-fourth of the members of the Association.

Now Reads:

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts, which shall be coextensive with the Congressional Districts in Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies.

Will Read:

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the

House of Delegates shall provide for the division of the State into Councilor Districts and for the organization of all component county societies in the districts into Councilor District Medical Societies.

Now Reads:

ARTICLE IX.

Officers

Sec. 1. Officers. The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor, and a Vice-Councilor, from each of the Councilor District Societies as provided in the By-Laws. All elections shall be held as prescribed in the By-Laws.

Sec. 2. Election and Eligibility. The officers of the Association shall be elected by the members during the annual session. No person shall be eligible to an elective office who has not been a member of the Association for the preceding three years.

Sec. 3. Terms of Officers. The President-Elect shall be elected annually. He shall become President on his installation at the close of the next annual session. If the President-Elect be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session. Other officers shall be elected for terms of one year each, except the Secretary-Treasurer and the Councilors who shall serve for three years. One-third of the Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

Will Read:

ARTICLE IX.

Officers

SEC. 1. DESIGNATIONS. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, the Immediate Past President, the Secretary, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, 10 Councilors and 10 Vice-Councilors as provided for in the By-Laws.

SEC. 2. ELECTION AND ELIGIBILITY. The officers of the Association shall be elected during the Annual Session as provided for in the By-Laws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.

SEC. 3. TERM OF OFFICE OF PRESIDENT-ELECT. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. If the President-Elect shall be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session.

SEC. 4. TERMS OF OTHER OFFICERS. Other officers shall be elected for terms of one year each except the Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates and the Councilors who shall serve for three years. One third of the Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

SEC. 5. SUCCESSOR TO THE PRESIDENT. If the President dies, resigns, or is removed from office, the First Vice-President shall immediately become President and shall serve for the remainder of the unexpired term. If the First Vice-President is unable to serve, then the Second Vice-President shall fill the office.

Now Reads:

ARTICLE X.

Funds and Expenses

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component county medical society. The amount of the assessment shall be set annually by the House of Delegates upon the recommendation of the Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates.

The Council shall submit an annual budget to the House of Delegates. The Council shall manage the finances of the Association and shall supervise all funds, investments and expenditures of the Association. All resolutions providing for appropriations, recommended by Council, shall be included in the annual budget, subject to final approval by the House of Delegates.

Will Read:

ARTICLE X.

Funds and Expenditures

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component county medical society. The amount of the assessment shall be set by the House of Delegates upon recommendation of Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner

approved by Council. The Council shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

Now Reads:

ARTICLE. XIII.

Amendments

The House of Delegates may amend this Constitution by a two-thirds vote of the Delegates present at any annual session, provided that such amendment shall have been presented to the House of Delegates at the previous annual session and that it shall have been published during the year in The Journal of the Association, or sent officially to each component county society at least two months before the annual session at which final action is to be taken.

Will Read:

ARTICLE. XIII.

Amendments

The House of Delegates may amend this Constitution at any session by a two-thirds vote of the Delegates present, provided that the proposed amendment shall have been introduced at the preceding session and provided that the proposed amendment shall have been published during the year in the JOURNAL.

Now Reads:

BY-LAWS
CHAPTER 1.

Membership

Sec. 1. Any physician holding the degree of Doctor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been adjudged guilty of moral turpitude or other serious crime, may be eligible for membership in a component society of the Association.

Will Read:

BY-LAWS
CHAPTER 1.

Membership

SEC. 1. A physician holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been judged guilty of moral turpitude or other serious crime, may be eligible for membership after being certified by the secretary of a component society as being a member in good standing of said component county society.

Now Reads:

Sec. 3. Membership in the Association shall be classified as active, associate, honorary, life and scientific.

Sec. 4. Active Members. All members shall be active, including the right to vote and hold office, unless otherwise classified by action of the component county society.

Sec. 5. Associate Members. Any physician who is not engaged in the regular practice of medicine for any one of the following reasons, namely: (1) during organized periods of hospital training and graduate education, (2) during periods of service in the Armed Forces, (3) after retirement or (4) for whom the payment of dues would constitute a hardship, may be classified by the component county society as an associate member. Associate Members shall be entitled to all the rights and privileges of the Association except that they shall not pay dues or receive The Journal without subscription thereto.

Sec. 6. Honorary Members. Eminent physicians and other persons who have distinguished themselves in the science of medicine, or for contributions to human welfare, may be elected to Honorary Membership in the Association by the House of Delegates upon nomination by any component county society and approval of the Committee on Professional Conduct of the Medical Association of Georgia. Such Honorary Members may be issued an appropriate certificate of membership without payment of dues.

Sec. 7. Life Member. A Life Membership may be granted by the House of Delegates, upon the recommendation of the component county society, to any physician who has had not less than forty years of active membership in the Association or has

passed his seventieth birthday. He shall not be subject to payment of dues.

Sec. 8. *Scientific Members.* There shall be created a new division of membership to be known as *Scientific Membership*. The privileges of membership under this classification shall entitle the holder thereof to all phases of the Association's activities pertaining to the study of scientific medicine, and shall include the right to attend all scientific meetings, postgraduate study courses, and scientific sessions of component organizations. Scientific members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to Medical Defense or to receive *The Journal* except by regular subscription.

Sec. 9. A physician who is under sentence of expulsion from a component county society, or whose name has been dropped from its roll of members, shall not be entitled to any of the rights, privileges or benefits of the Association, nor shall he be permitted to take part in any of its proceedings.

Sec. 10. The cause of the failure of a practicing physician to affiliate himself with an available component county society, at any time, shall be ascertained before election to membership.

Sec. 11. Eligible physician members of the State and Federal medical services and full time members of approved medical faculties not engaged in private practice of medicine shall pay half the annual dues of the Association provided similar action has been taken by the component county society.

Will Read:

SEC. 3. Membership in the Association shall be classified as Active, Service, Associate and Honorary.

SEC. 4. **ACTIVE MEMBERS.** Physicians who are members in a component county medical society and are eligible to vote and hold office in the society shall be Active members, unless otherwise classified by action of the component county society. These members shall have full privileges of Association membership including the right to hold office and vote, the privilege of Medical Defense and receipt of the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, and these members shall pay full dues to the Association annually. New members entering practice after July 1st may pay one half the annual dues.

Active members may be excused from the payment of Association dues for one of the following reasons: financial hardship or illness, post-graduate training, defined as that period during which a member participates in an organized training course within a hospital, and being retired from active practice. A member in good standing who is over 70 years of age may also be excused from the payment of Association dues upon his application to the Association through his component county society; this exemption to begin the year following the member's 70th birthday. Active members excused from the payment of Association dues shall have the right to vote and hold office but shall not have the privilege of Medical Defense and shall not receive any publication of the Association except by personal subscription.

SEC. 5. **SERVICE MEMBERS.** Physicians eligible for Service membership are all full-time commissioned Medical Officers in the Regular or Reserve U. S. Army, Navy, Air Force and Indian Service, and those physicians who have been retired from the Services by Federal law and who do not engage in active practice. These members shall not have the right to hold office and vote, and shall not receive any publication of the MAG except by personal subscription, nor shall they receive the privilege of Medical Defense. These members shall not be required to pay annual dues for the period beginning January 1 or July 1 following the date of the member's entrance into service.

SEC. 6. **ASSOCIATE MEMBERS.** Associate membership may be granted to physicians who are engaged in State, County and Federal medical services and full-time salaried members of approved medical faculties not engaged in the private practice of medicine provided similar action has been taken by the component county society. Associate membership may also be granted to those members of component county societies who are not eligible for Active membership in the component county societies. Associate members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to the privilege of Medical Defense or to receive any publication of the Association except by personal subscription.

SEC. 7. **HONORARY MEMBERS.** Physicians who have risen to prominence in the profession may be elected to Honorary membership by the House of Delegates. Nominations for Honorary membership may be submitted to the House of Delegates by component county societies or Council. These members shall enjoy all the privileges of the Association but shall not vote or hold office nor shall they receive the privilege of Medical Defense or

any publication of the Association except by personal subscription.

SEC. 8. **TENURE.** When the Secretary is officially informed that a member is not in good standing in his component society, he shall remove the name of that member from the Membership roll.

SEC. 9. **TRANSFER.** Should a member remove his practice to another jurisdiction he shall apply for a continuance of his membership through the component society in the jurisdiction to which he has moved his practice.

Now Reads:

(CHAPTER II.)

Sec. 2. The program for the general meetings shall be prepared by the Committee on Scientific Work and approved by the executive committee of the Council at least 60 days before the Annual Session of the Association and published in the issue of *The Journal* preceding the Annual Session.

Will Read:

SEC. 2. The program for the general meetings shall be prepared by the Committee on Scientific Work and approved by the Executive Committee of Council at least 60 days before the Annual Session of the Association and published in an issue of the JOURNAL preceding the Annual Session.

Now Reads:

Sec. 3. All papers read before the meetings shall become the property of the Association, and shall be deposited with the Secretary-Treasurer immediately after being read. Failure to comply with this and other rules set forth by the Committee on Scientific Work regarding papers, discussions and exhibits shall automatically bar scheduled participation in the scientific sessions in the future from this member for a period of not less than five years unless he presents an acceptable excuse.

Will Read:

SEC. 3. All papers read before meetings shall be deposited with the Secretary or the presiding officer and shall become the property of the Association. Without an acceptable excuse, failure to comply with this and other rules as regard the Annual Session as set forth by the Committee on Scientific Work, shall automatically prohibit a member from participating in scheduled scientific sessions for a period of not less than five years.

Now Reads:

Sec. 4. Upon invitation of the President any physician may register at a general meeting of the Association as a guest upon presentation of adequate evidence of membership in good standing in a component unit of the American Medical Association.

Distinguished lay persons and physicians may be invited as special guests of the Association by the President or by action of the Council. Privileges of the floor may be extended to guests at the discretion of the presiding officer.

Will Read:

SEC. 4. The general meetings shall be open to all registered members. Distinguished lay persons and guest physicians may be invited as special guests of the Association by the President or by action of Council.

SEC. 5. **LOCAL ARRANGEMENTS COMMITTEE.** At the close of each Annual Session, the component society which will act as host at the next Annual Session, shall elect Local Arrangements Committees which shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of Council.

Now Reads:

CHAPTER III.

House of Delegates

Sec. 1. The House of Delegates shall meet on the first and last day of the annual session at a time fixed by the Council and at such other times as may be necessary for the transaction of the business of the Association.

Will Read:

CHAPTER III.

House of Delegates

SEC. 1. **MEETINGS.** The House of Delegates shall meet during the Annual Session at a time and place fixed by Council. The House of Delegates may also meet in interim sessions and at such other times as may be necessary for the transactions of the business of the Association as may be determined by Council.

Now Reads:

Sec. 2. Each component county society shall elect one delegate and a corresponding alternate for each twenty-five members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. It shall be the duty of the President to have the representation of each component county society checked by the Committee on Credentials at the time of the annual session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy.

Will Read:

SEC. 2. Each component county society shall elect one delegate and a corresponding alternate, each of whom who has been a member in good standing for the prior three years, for each 25 members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. Delegates to the House of Delegates shall serve for a term of three years; one-third of the members of the House of Delegates to be elected annually provided that the component county societies which are entitled to three or more delegates shall elect at their first election, one-third of their delegation for a term of one year, one-third of their delegation for a term of two years and one-third of their delegation for a term of three years and thereafter elect such delegates whose terms of office expire therewith. Those component county societies which are entitled to less than three delegates shall elect their delegate or delegates for staggered terms in rotation as may be determined by Council until one-third of the House of Delegates is being elected annually.

Now Reads:

Sec. 5. The Secretary-Treasurer of the Association shall be the Secretary of the House of Delegates or, in his absence, by a delegate appointed by the President. The Executive Secretary may serve in this capacity.

Will Read:

SEC. 5. The Secretary of the Association shall be the Secretary of the House of Delegates or, in his absence, a Delegate appointed by the Speaker of the House of Delegates shall serve as Secretary of the House of Delegates. The Executive Secretary may serve in this capacity.

Now Reads:

Sec. 6. The following shall be the general Order of Business at all meetings of the House of Delegates : 1. Call to order by the President; 2. Roll Call; 3. Election of Speaker and Speaker pro tem; 4. Reading and adoption of minutes; 5. Reports of officers; 6. Reports of Committees; 7. Unfinished business; 8. New business.

Will Read:

SEC. 6. The following shall be the general Order of Business at all meetings of the House of Delegates: 1. Call to Order by the Speaker; 2. Roll Call; 3. Reading and Adoption of Minutes; 4. Reports of Officers; 5. Reports of Committees; 6. Unfinished Business; 7. New Business. At any meeting, the House by majority vote may change the Order of Business. New Business may be introduced at the final meeting of the House of Delegates only when such business is of an emergency nature or introduced by unanimous consent.

Now Reads:

Sec. 7. For the purpose of expediting proceedings the President shall appoint from the members of the House of Delegates the Reference Committees and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in the debate, but shall not have the right to vote.

Will Read:

SEC. 7. For the purpose of expediting proceedings, the Speaker of the House of Delegates shall appoint from the members of the House of Delegates the Reference Committees and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in the debate, but shall not have the right to vote.

Now Reads:

(CHAPTER IV.)

Sec. 2. The Council shall be composed of the President, the President-Elect, Vice-Presidents, Secretary-Treasurer, and one Councilor or Vice-Councilor from each Councilor district. Each Councilor and Vice-Councilor shall be nominated by each district society at the time of its annual meeting. In the event of a vacancy in the office of a Councilor and Vice-Councilor, the vacancy may be filled temporarily by appointment by the President from members of that district society.

Will Read:

CHAPTER IV.

Council

SEC. 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice-Presidents, the Secretary, Speaker of the House of Delegates, or the Vice-Speaker of the House of Delegates and one Councilor or Vice-Councilor from each Councilor District. Vice-Councilors shall be *ex-officio* members of Council except in the absence of their respective Councilors when they shall serve as Councilors. The Vice-Speaker shall be an *ex-officio* member of Council except in absence of the Speaker, then he shall in the Speaker's stead. The Treasurer, Editor of the JOURNAL, Executive Secretary and Delegates to the AMA shall be *ex-officio* members of Council without the right to vote.

Now Reads:

Sec. 4. The Chairman of the Council shall be elected annually at the organization meeting and shall serve one year, or until his successor is elected. He shall preside over its meetings and appoint all necessary committees. A Vice-Chairman shall be elected from among its members. The Secretary-Treasurer of the Association shall be the Secretary of the Council.

Will Read:

SEC. 2. CHAIRMAN AND SECRETARY. A Chairman and Vice-Chairman of Council shall be elected annually at the organizational meeting and shall serve for one year, or until their successors are elected. The Chairman or Vice-Chairman shall preside over meetings of Council and appoint all necessary committees. The Secretary of the Association shall serve as Secretary of Council.

Now Reads:

Sec. 3. The Council shall set up an Executive Committee composed of the President, Secretary-Treasurer, Chairman of the Council and two other members of the Council. The President shall be the chairman of the Executive Committee. It shall meet not less often than bi-monthly to review the affairs of the Association. The Committee shall make recommendations to the Council and shall carry out such items of business as are referred to it by the Council.

Will Read:

SEC. 3. EXECUTIVE COMMITTEE. The Council shall organize an Executive Committee at the first meeting. The Executive Committee shall be composed of the President, the President-Elect, the Immediate Past President, the Secretary, the Chairman of Council, who shall serve as presiding officer, and the Chairman of the Council Committee on Auditing and Appropriations. It shall meet at intervals of not more than four months apart between the meetings of Council. The Committee shall make such recommendations to the Council and shall carry out such items of business as are referred to it by Council. The Executive Committee shall appoint all committee chairmen and committees of the Association not otherwise provided for, subject to confirmation by Council, and shall serve as Publications Committee of the JOURNAL. The Executive Committee shall appoint a Treasurer of the Association annually as provided for in these By-Laws.

Now Reads:

Sec. 1. The Council shall meet on the last day of the annual session of the Association to organize and at intervals of not more than four months apart until the next annual session. Special meetings of the Council may be held on the call of the President or upon request of three members of the Council.

Will Read:

SEC. 4. MEETINGS. The Council shall meet at the close of the Annual Session to organize and at intervals of not more than four months apart until the next Annual Session. Special meetings of Council may be held on the call of the President or upon

request of three members of Council. Regular meetings of Council will be held on the call of the Chairman.

Now Reads:

Sec. 5. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws.

Sec. 12. The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the annual session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it for the good of the Association without restriction.

Sec. 14. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between annual sessions of the Association. The appointee shall serve until his successor has been elected and installed.

Sec. 17. The Council shall provide such headquarters for the Association as may be required to conduct its affairs.

Will Read:

SEC. 5. GENERAL DUTIES. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall provide such headquarters for the Association as may be required to conduct its affairs. The Council shall by appointment fill any vacancy in office not otherwise provided for, which may occur during the interval between Annual Sessions of the Association. The appointee shall serve until his successor has been elected and installed.

The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the Annual Session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it without restriction for the good of the Association.

Now Reads:

Sec. 10. The Council shall provide for and superintend the issuance of all necessary publications of the Association, including proceedings, transactions and memoirs.

Sec. 15. The Council may appoint an Assistant Secretary-Treasurer or an Executive Secretary—either or both and fix their terms of employment.

Sec. 16. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association subject to approval of the House of Delegates.

Will Read:

SEC. 6. SPECIFIC DUTIES. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association and may appoint an Assistant Secretary and/or Executive Secretary—either or both and fix their terms of employment. The Council shall control and direct all Association publications.

Now Reads:

Sec. 6. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to the Association. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

Will Read:

SEC. 7. BOARD OF CENSORS. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to the Association. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association or upon the request of the party concerned. It shall hear and decide all questions of discipline

affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

Now Reads:

Sec. 7. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in, the betterment of the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

Will Read:

SEC. 8. COUNCILOR AND VICE-COUNCILOR DUTIES. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in the betterment of, the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the Annual Session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

Now Reads:

Sec. 11. The Chairman of the Council shall appoint from among its members, a committee of three members to be known as the Committee on Auditing and Appropriations, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each annual session. This proposed budget shall be prepared by the Committee on Auditing and Appropriations for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval after which it becomes effective. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Sec. 13. The Council shall appoint, at least six months before the annual session, a committee, consisting of three or more of its members, to be known as the Committee on Arrangements for the annual session. This committee shall appoint a general chairman of a local committee on arrangements, who shall be a member of the component society in which the annual session is to be held. This local Chairman shall appoint, from the members of his county society, the personnel of the local committee on arrangements. The local committee on arrangements shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements for the annual session. All expenditures made by that committee in connection with the annual session must be authorized in advance by the Committee on Auditing and Appropriations of the Council. Immediately after the annual session the Committee on Arrangements of the Council shall forward to the Secretary-Treasurer any accumulated balance. Any deficit created on account of the annual session shall be met by the Council on recommendation of the Committee on Auditing and Appropriations.

Sec. 18. The Council shall have control of all technical exhibits at the annual sessions.

Will Read:

SEC. 9. COMMITTEE ON AUDITING AND APPROPRIATIONS. The Chairman of the Council shall appoint from among its members, a committee of three members to be known as the Committee on Auditing and Appropriations, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each Annual Session. This proposed budget shall be prepared by

the Committee on Auditing and Appropriations for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committees in connection with the Annual Session must be authorized in advance by the Committee on Auditing and Appropriations. Council shall have control of all commercial exhibits at the Annual Sessions and any deficit created on account of the Annual Session shall be met by Council on recommendation of the Committee on Auditing and Appropriations.

Now Reads:

CHAPTER V.

Election of Officers

Sec. 1. The President-Elect, Vice-Presidents, Secretary-Treasurer, Councilors and Vice-Councilors shall be elected by ballot by the members of the Association. Nominations for these officers except Councilors and Vice-Councilors shall be made orally as the last order of business at the first meeting on the first day of the scientific session. No nominating or seconding speech shall exceed two minutes. The President shall appoint a Committee of not less than three Tellers immediately after the close of nominations who shall have charge of the election.

Sec. 2. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations for Councilor and Vice-Councilor from such district shall be made from the floor. One third of the Councilors and Vice-Councilors shall be elected annually.

Will Read:

CHAPTER V.

Election of Officers

SEC. 1. ELECTION. The President-Elect, two Vice-Presidents, Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, Councilors and Vice-Councilors shall be elected by ballot by members of the Association during the Annual Session. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. Other officers shall be elected for terms of one year each except the Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, Councilors and Vice-Councilors who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually.

SEC. 2. NOMINATION. Nominations for these officers except Councilors and Vice-Councilors shall be made orally from the floor as the last order of business at the first General Session of the Annual Session and no nominating or seconding speech shall exceed two minutes. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the Annual Session. If no nomination is presented by a district society in this manner, nominations shall be made from the floor.

Now Reads:

Sec. 3. The Secretary-Treasurer shall have prepared in advance an official ballot. One ballot shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in a locked ballot box provided by the Secretary-Treasurer and kept in the custody of the Tellers designated by the President. The key shall be kept by the Chairman of the Tellers.

Sec. 4. Voting shall take place during the hours of the scientific program up to 10:30 a. m. of the last day of the annual session. At that time the Committee of Tellers appointed by the President shall count the ballots and report their findings to the members at the last meeting of the Association. The candidate for President-Elect receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select the President-Elect from the two candidates having the highest number of votes by secret ballot. Other officers shall be elected by receiving the highest number of votes on the first ballot.

Sec. 5. Delegates and Alternates to the American Medical Association shall be elected in the same manner and at the same time and in accordance with the Constitution and By-Laws of

the American Medical Association.

Will Read:

SEC. 3. METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box which shall be kept in the custody of the Tellers Committee. One ballot *only* shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SEC. 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the Annual Session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

SEC. 5. Delegates and Alternates to the American Medical Association shall be elected in the same manner and at the same time and in accordance with the Constitution and By-Laws of the American Medical Association.

Now Reads:

CHAPTER VI.

Duties of Officers

Sec. 1. The President. The President shall preside at the organization meeting of the House of Delegates and at all meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an address at such time during the annual session as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession and of the Association in the State during his term of office. So far as practicable he shall visit by appointment the various district societies, and shall assist the Councilors in building up the county societies, and in increasing the prestige of the Association. He shall be a member of the Council and its Executive Committee, and shall be a member of all committees of the Association with the authority to call a meeting of any Committee when necessity demands it or after failure of the chairman to do so. With the consent of the Council he shall terminate any committee whose function has been fulfilled. It shall be his duty with the approval of the Council, to replace any member of any committee who fails to show interest in performing the duties assigned to him.

Will Read:

CHAPTER VI.

Rights and Duties of Officers

SEC. 1. PRESIDENT. The President shall (A) preside at all general meetings of the Association; (B) address the opening General Session of the Annual Session; (C) assist the Councilors in improving the county and district societies as far as practicable; (D) serve as a member of Council and as a member of its Executive Committee; (E) serve as a member of all committees of the Association with the authority to call a meeting of any committee when necessity demands it or after failure of the chairman to do so. With the approval of Council, he may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned to him; (F) he shall be an *ex-officio* member of the House of Delegates without the right to vote.

Now Reads:

Sec. 2. The President-Elect. The President-Elect shall be a member of the Council, and shall be a member ex-officio of all standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and the Standing Committees.

Will Read:

SEC. 2. PRESIDENT-ELECT. The President-Elect shall be a member of the Council and of its Executive Committee, and shall be a member *ex-officio* of all standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and, when possible, the standing committees. He shall be an *ex-officio* member of the House of Delegates without the right to vote.

Now Reads:

Sec. 4. *The Secretary-Treasurer.* (a) *The Secretary-Treasurer or his representative shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and its Executive Committee and an ex-officio member of all committees.*

Sec. 4. (b) *He shall be custodian of all record books and papers belonging to the Association and shall keep account of all funds of the Association which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his*

status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall supply all component societies with the necessary blanks for making their annual reports, and shall collect the regular per capita assessments from the component societies. The amount of his salary shall be fixed by the Council.

Will Read:

SEC. 4. (A) SECRETARY. The Secretary or his representative shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be Secretary of the Council and its Executive Committee and an *ex-officio* member of the House of Delegates and all committees of the Association.

SEC. 4. (B) He or the Executive Secretary shall be custodian of all record books and papers belonging to the Association. He shall provide for the registration of the members and delegates at the Annual Session. He shall, with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall supply all component societies with the necessary blanks for making their annual reports, and shall collect the regular per capita assessments from the component societies. The amount of his salary shall be fixed by the Council.

Additions to Chapter VI Will Read:

SEC. 5. IMMEDIATE PAST PRESIDENT. The Immediate Past President shall serve for one year immediately following his term of office as President. He shall serve on the Council and its Executive Committee and shall be an *ex-officio* member of the House of Delegates without the right to vote.

SEC. 6. SPEAKER. The Speaker of the House of Delegates shall serve for three years and shall preside over all meetings of the House of Delegates. It shall be his duty to preserve order and to follow the proper parliamentary procedures. It shall be the duty of the Speaker to have the representation of each component county society checked by the Committee on Credentials at the time of the Annual Session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy. He shall serve as a member of Council.

SEC. 7. VICE-SPEAKER. The Vice-Speaker of the House of Delegates shall serve for three years and shall preside over the House of Delegates in the absence of the Speaker. In the event of the Speaker's death, resignation or inability to serve, the Vice-Speaker shall succeed him for the unexpired term. He shall serve as a member of Council in the absence of the Speaker.

Now Reads:

CHAPTER VII.

Component County Societies and District Societies

Sec. 1. *County and District Societies.* All county and district societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state which have

adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitution and by-laws shall have been submitted to the Council and received its approval. A component society shall consist of three or more active members.

Will Read:

CHAPTER VII.

Component County Societies

SEC. 1. COUNTY SOCIETIES. All county societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state which have adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitution and by-laws shall have been submitted to the Council and received its approval. A component society shall consist of three or more active members.

Now Reads:

Sec. 2. *Charter.* Upon application to and recommendation by the Council, the House of Delegates shall provide and issue charters to county and district medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary-Treasurer. The House of Delegates shall have authority to revoke the charter of any component county society or district society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws. Only one component county society shall be chartered in each county.

Will Read:

SEC. 2. CHARTER. Council shall provide and issue charters to county medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws. Only one component county society shall be chartered in each county.

Now Reads:

Sec. 3. *Names of Societies.* The name and title of each component county society and district society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of The Medical Association of Georgia.

Sec. 4. *Custody of Charter.* The charter of each component county society and district society as issued by The Medical Association of Georgia, shall be preserved and shall be in the custody of the secretary of such society at all times.

Will Read:

SEC. 3. NAMES OF SOCIETIES. The name and title of each component county society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of The Medical Association of Georgia.

SEC. 4. CUSTODY OF CHARTER. The charter of each component county society as issued by the Medical Association of Georgia, shall be preserved and shall be in the custody of the secretary of such society at all times.

Now Reads:

Sec. 5. *Constitutions and By-Laws.* Each component county society and district society shall have a constitution and by-laws. These shall be in conformity with the Constitution and By-Laws of The Medical Association of Georgia, and a copy thereof shall be transmitted to the headquarters of The Medical Association of Georgia for approval and record.

Sec. 6. *Purposes and Duties.* Each component county society shall have general direction of the affairs of the profession in the county and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

Sec. 7. *Official Records.* The official copy of the constitution and by-laws of each component county society shall be kept in a special book provided for that purpose. In it shall be entered all amendments which have been ratified by the Council of The Medical Association of Georgia. It shall contain the signature of each member who is entitled to membership in The Medical Association of Georgia, together with the date of his election, decease, resignation or expulsion. It shall be the duty of the

secretary to preserve this book and hold it available when required for reference.

Will Read:

SEC. 5. PURPOSES. Each component county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts must be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county or counties in its jurisdiction.

SEC. 6. DUTIES. Each component county society shall meet the following five minimum standards: Each society shall (1) meet a minimum of four times a year, elect officers and delegates annually at a meeting before January 1st and report these officers to the headquarters office before January 1st; (2) maintain an up to date Constitution and By-Laws in conformity with the Constitution and By-Laws of the Medical Association of Georgia and shall transmit a copy of its Constitution and By-Laws to the headquarters office for approval and record; (3) maintain a Board of Censors and/or a Mediation Committee; (4) maintain minutes of each meeting in a permanent record book that will be available at all times; (5) maintain at its minimum four meetings annually scheduled programs.

Now Reads:

Sec. 8. *Delegates and Alternates.* Each component county society at its annual meeting shall elect delegates and alternates to represent it in the House of Delegates of the Association in accordance with these By-Laws, unless other definite procedure for the selection of delegates is provided in its constitution and by-laws. The secretary of each component county society shall send a list of such delegates to the Secretary-Treasurer of the Association at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with these provisions. In the absence of, or the disability or disqualification of a delegate, the vacancy shall be filled by the President from other members of the same component county society.

Will Read:

SEC. 7. DELEGATES. Each component county society shall elect at its annual meeting prior to January 1st Delegates and Alternates to the House of Delegates in accordance with these By-Laws. The secretary of each component society shall send a list of such delegates to the Secretary of the Association before January 15th. In the absence of, or the disability or disqualification of, a Delegate, the vacancy may be filled by the President of the society from other members of the same component society, provided such vacancy is filled prior to the first session of the House of Delegates.

Now Reads:

Sec. 9. *Combined Counties.* The House of Delegates shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district or other classes of societies. Such societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for component county societies.

Sec. 10. *Annual Meeting.* Each component county society shall designate the meeting held nearest to January 1st of each year as its annual meeting, at which time delegates to the House of Delegates, and a local member of the sub-committee on Legislation and sub-committee on Public Health will be chosen, and their names forwarded promptly to the Secretary of the Association.

Sec. 11. *Purposes and Duties of District Societies.* District Societies shall have one or more meetings during the year. A Councilor and a Vice-Councilor shall be nominated at the appropriate annual meeting and forwarded to the Secretary of the Association to be elected by the Association for terms of three years in a rotating manner with other district societies. At the same time, each shall elect a member to the sub-committees on Legislation and Public Health of the Association.

Will Read:

SEC. 8. COMBINED COUNTIES. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies. These societies when chartered shall be entitled to all the rights and privileges provided for component societies. A physician residing in a county not

having a component society shall be referred to an adjacent component county society by Council.

SEC. 9. ANNUAL MEETING. Each component county society shall designate a meeting held prior to January 1st as its annual meeting, at which time Officers and Delegates for the next year shall be elected and their names forwarded before January 15th to the Secretary of the Association.

SEC. 10. DISTRICT SOCIETIES. District Societies shall have one or more meetings during the year and shall nominate a Councilor and Vice-Councilor as provided in these By-Laws. These district societies shall be organized for the best interests of the medical profession in Georgia and shall not necessarily conform with the boundaries of congressional districts. District societies shall elect officers, adopt a Constitution and By-Laws in conformity with the Constitution and By-Laws of the Medical Association of Georgia and levy dues for the government of its own affairs.

(CHAPTER IV.)

Now Reads:

Sec. 4. (c) *He shall give bond in the amount of a sum to be fixed by the Council. He shall receive all funds of the Association, together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at the last meeting of the fiscal year at the annual session of the Association. This shall consist of an itemized statement of all financial transactions of the past year, all accounts made, money received and disbursed with vouchers attached. The fiscal year includes the period of time between January 1st and December 31st. This financial report shall be published in The Journal as soon as practicable after the end of each fiscal year.*

Will Read:

CHAPTER VIII.

Funds and Expenditures

SEC. 1. TREASURER. The Treasurer shall be appointed annually by the Executive Committee of Council subject to the approval of Council. The Treasurer shall be a member in good standing for at least three years prior to his appointment and may be the same person as the Secretary. The Treasurer shall not be an officer of the Association but shall be an *ex-officio* member of Council and the House of Delegates without the right to vote. He shall be an *ex-officio* member of the Committee on Auditing and Appropriations. The Treasurer shall give bond in such sum as may be fixed by the Council, the premium on such bond to be paid by the Association.

SEC. 2. TREASURER'S DUTIES. The Treasurer shall receive all funds of the Association together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at its last meeting of the fiscal year. The fiscal year includes the period of time between January 1st and December 31st. A financial report shall be published in THE JOURNAL as soon as practicable after the end of each fiscal year. All checks for Association expenditures shall be signed by both the Treasurer and the Secretary, or by two officers of the Association designated by Council.

Now Reads:

CHAPTER VIII.

Dues and Assessments

Sec. 1. *The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the Secretary-Treasurer of the Association. Neither shall the Secretary-Treasurer of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.*

An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval by his county society.

Sec. 2. The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

Sec. 3. For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

Sec. 4. Any county society which fails to make the reports required before the annual session of the Association, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

Will Read:

SEC. 3. (a) DUES AND ASSESSMENTS. The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the active members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association before January 1st the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the headquarters office of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the headquarters office of the Association. Neither shall the headquarters office of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.

An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval by his county society.

SEC. 3. (b) The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

SEC. 3. (c) For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

SEC. 3. (d) Any county society which fails to make the reports required before the annual session of the Association shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

Now Reads:

CHAPTER IX.

Standing Committees

Sec. 1. The Standing Committees of the Association shall be as follows:

- (A) Committee on Scientific Work
- (B) Committee on Legislation
- (C) Committee on Medical Education
- (D) Committee on Medical Defense
- (E) Committee on Professional Conduct
- (F) Committee on History and Vital Statistics
- (G) Committee on Public Health
- (H) Committee on Maternal and Infant Welfare
- (I) Committee on Rural Health
- (J) Committee on Industrial Health
- (K) Committee on Public Relations
- (L) Committee on Cancer
- (M) Committee on Insurance
- (N) Committee on Veterans Affairs
- (O) Committee on Constitution & By-Laws
- (P) Committee on Awards
- (Q) Committee on Woman's Auxiliary
- (R) Committee on Hospitals

Will Read:

CHAPTER IX.

Standing Committees

SEC. 1. The Standing Committees of the Association shall be as follows:

- (A) Committee on Scientific Work
- (B) Committee on Legislation
- (C) Committee on Medical Education
- (D) Committee on Medical Defense
- (E) Committee on History and Vital Statistics
- (G) Committee on Public Health
- (H) Committee on Maternal and Infant Welfare
- (I) Committee on Rural Health
- (J) Committee on Industrial Health
- (K) Committee on Public Service
- (L) Committee on Cancer
- (M) Committee on Insurance and Economics
- (N) Committee on Veterans Affairs
- (O) Committee on Constitution & By-Laws
- (P) Committee on Scientific Awards
- (Q) Committee on Woman's Auxiliary
- (R) Committee on Hospitals
- (S) Committee on Crawford W. Long Memorial Hospital
- (T) Committee on Mental Health

Now Reads:

Sec. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. One member of each standing committee shall be appointed each year by the President to serve for three or more years as required by each committee and announced at the time of the final meeting of the Association each year. Provided that for the first year the President shall appoint three or more members as required with one member to serve for the necessary graduated period of years to meet these requirements. Failure of a member to carry out the duties of his committee assignment during any year shall automatically cause his removal at the time of the annual session and the President, with the consent of the Council, shall appoint another member to fill his unexpired term. All committees shall make an annual report in writing to the Association headquarters office sixty days in advance of the Annual Session.

Will Read:

SEC. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three year. Unless otherwise provided in these By-Laws, Executive Committee of Council shall appoint standing committee members and standing committee chairmen as needed. One member of each standing committee shall be appointed each year by the Executive Committee of Council to serve for three years. The Executive Committee shall make all appointments at least 30 days prior to the Annual Session and all standing committees shall hold their organizational meeting at the time of the Annual Session. The members of each committee shall serve staggered terms of office so that only one term shall expire each year. Failure of a member to carry out the duties of his committee assignment shall automatically cause his removal by the President on recommendation from the committee chairman, and, with the consent of Council, the President shall appoint another member to fill his unexpired term. All committee chairmen shall make an annual report in writing of not more than 500 words to the Association headquarters office 60 days in advance of the Annual Session for consideration by the House of Delegates.

Now Reads:

(A) The Committee on Scientific Work. The Committee on Scientific Work shall be composed of five members: the President, the Secretary-Treasurer and three members appointed for terms of three years each. The senior appointed member shall serve as chairman. The duties of the Committee on Scientific Work shall be to prepare and publish the Scientific Program of the annual session, subject to the approval of Council. It shall also prepare and publish all rules and regulations governing the selection and presentation of papers, discussions and Scientific Exhibits before the general meetings and shall present them for publication in The Journal of the Association.

The presentation of Scientific Exhibits for the annual session shall be under the direction of this committee. For this purpose, the committee may set up a sub-committee of three or more members with representatives from the two medical schools of the State.

All lectureships of the Association shall be under the control of this committee, but special sub-committees may be established to advise the committee concerning the selection of proper speakers for each lectureship. These special lectures shall be given before the general meetings at a time selected by the Committee on Scientific Work.

Will Read:

(A) **COMMITTEE ON SCIENTIFIC WORK.** The Committee on Scientific Work shall be composed of six members: the President, the Secretary, the Chairman of the Auditing and Appropriations Committee and three members appointed for terms of three years each. The senior appointed member shall serve as chairman. The duties of the committee shall be to prepare and publish the Scientific Program of the Annual Session, subject to the approval of Council. It shall make all rules and regulations governing the selection and presentation of papers, discussions and scientific exhibits before the general meetings. It may divide the scientific work into whatever number of sections that seem advisable for the particular Annual Session. As each section becomes established it shall elect its own officers subject to such rules and regulations as may be laid down by the Committee on Scientific Work.

All lectureships of the Association shall be under the control of this committee, but special sub-committees may be established to advise the committee concerning the selection of proper speakers for each lectureship. These special lectures shall be given before the general meetings at a time selected by the Committee on Scientific Work.

Now Reads:

(B) *The Committee on Legislation. The duties of the Committee on Legislation shall be to represent the Association in securing and enforcing legislation in the interests of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local and national affairs. It shall further the education of the general public in health matters fostering a sane point of view about proper medical care.*

Each component county society and district society shall designate one member at its annual meeting to serve with the Committee on Legislation in an active capacity. Vacancies in this special sub-committee shall be filled by the President. In addition, the Woman's Auxiliary shall be requested to form a similar committee with representatives from each component auxiliary. The President may appoint for one year an Advisory Committee of any number he deems advisable.

Will Read:

(B) **COMMITTEE ON LEGISLATION.** The Committee on Legislation shall be composed of a chairman, who shall have charge of matters pertaining to State of Georgia legislation; a vice-chairman, who shall have charge of matters pertaining to legislation of the Congress of the United States; three other members and the chairmen of the following committees: Medical Education, Public Health, Maternal and Infant Welfare, Rural Health, Industrial Health, Insurance, Veterans Affairs, Hospitals and Mental Health. The President of the State Board of Medical Examiners and the Chairman of the State Board of Health shall also be members of the committee. The duties of the committee shall be to represent the Association in securing and enforcing State of Georgia and Federal legislation in the interests of public health and scientific medicine. The committee shall meet at least 60 days prior to the convened sessions of either the Georgia General Assembly or the Congress of the United States. The committee shall appoint at least 10 keymen, one from each congressional district, to represent the committee in their area on matters pertaining to legislation of the Congress of the United States. As many other keymen as are needed shall be appointed to represent the committee on matters pertaining to State of Georgia legislation.

Now Reads:

(G) *The Committee on Public Health. The Committee on Public Health shall be assisted by a sub-committee of one member elected by each county and district society of the state. Its duty shall be to advise with the Governor and other State officials, and with the Georgia State Board of Health and other related groups in regard to all matters concerning the health of the citizens of Georgia. It shall meet at the time of each session*

of the Georgia State Legislature with the Committee on Legislation to give assistance in carrying out its duties.

The President may appoint for one year an Advisory Committee of any number he deems advisable.

Will Read:

(G) **THE COMMITTEE ON PUBLIC HEALTH.** The Committee on Public Health shall be composed of a chairman and a member of the Georgia State Department of Health appointed by the Executive Committee of Council of the Medical Association of Georgia and the chairman of each of the following Association committees: Industrial Health; Rural Health; Hospitals; Legislation; Medical Civil Preparedness; Mental Health; Crippled Children; Maternal and Infant Welfare; Chronic Illness; Cancer; Insurance Board; and Blood Banks. The chairmen of these committees shall then automatically be members of the Association's Public Health Committee and shall select an alternate member from each of their respective committees to represent them at Public Health Committee meetings in the absence of the chairman. It shall be the duty of the Public Health Committee to meet at least annually to hear reports from the committee chairmen members so named, to correlate their activities and to act as a "clearing house" for any matters concerning public health. It shall also be the duty of the Public Health Committee to correlate these activities with the Georgia Department of Public Health."

Now Reads:

(H) *The Committee on Maternal and Infant Welfare shall be composed of seven members, three of whom shall be general practitioners. It shall regularly review and analyze the causes of all maternal deaths occurring in the State. It shall investigate conditions affecting maternal care in Georgia and make recommendations concerning improvements thereof. It shall establish a working liaison with the Georgia State Obstetrical and Gynecological Society and the Georgia Pediatric Society and shall consider the establishment of annual post-graduate regional courses in obstetrics throughout the State with the cooperation of the Committee on Medical Education and Hospitals.*

Will Read:

(H) **COMMITTEE ON MATERNAL AND INFANT WELFARE.** The Committee on Maternal and Infant Welfare shall be composed of three or more general practitioners, three or more obstetricians and three or more pediatricians. Terms of office shall be for a period of three years with one third of the members appointed annually by the Executive Committee of Council. The committee shall regularly review and analyze the causes of all maternal deaths and perinatal losses occurring in the State for the purpose of recommending improvement. It shall also investigate conditions affecting maternal and infant care in Georgia and make recommendations concerning improvements thereof. The committee shall meet a minimum of twice annually.

Now Reads:

(K) *The Committee on Public Relations shall be appointed by the President. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.*

Will Read:

(K) **THE COMMITTEE ON PUBLIC SERVICE** shall be appointed by the Executive Committee of Council. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.

Now Reads:

(M) *The Committee on Insurance or Insurance Board shall consist of not less than five members appointed for a period of five years in rotation by the President. The committee may elect one of its members to be chairman or request the President to designate a member as chairman. Members appointed during*

the first four years shall serve staggered terms as designated by the President.

The four geographical quadrants and the central industrial area shall have representation on this committee. Also the chairman may nominate five lay persons with known interest in the field of insurance for appointment by the President, who shall serve with the Board in an advisory capacity.

It shall be the duty of this committee to formulate and administer all policies and plans pertaining to insurance insofar as such concern members of the Association. In particular it shall sponsor and promote the Georgia Plan including provision for necessary expenses.

Will Read:

(M) COMMITTEE ON INSURANCE AND ECONOMICS. The Committee on Insurance and Economics or Insurance Board shall consist of not less than 10 members, one from each councilor district, to be appointed for a period of three years in rotation by the Executive Committee of Council and the Executive Committee shall appoint one of these chairman. The chairman may nominate lay persons with known interest in the field of insurance for appointment by the Executive Committee to serve in an advisory capacity.

It shall be the duty of this committee to formulate and administer all policies and plans pertaining to insurance insofar as such concern members of the Association. In particular it shall sponsor and promote the Georgia Plan including provision for necessary expenses.

Now Reads:

(P) *The Committee on Awards shall have complete charge of all awards made by the Association or in the name of the Association. The decisions of this Committee shall be final in reference to recipients.*

Will Read:

(P) THE COMMITTEE ON SCIENTIFIC AWARDS shall have complete charge of all awards made by the Association or in the name of the Association for scientific exhibits at the Annual Session.

Additions as Follows:

(S) COMMITTEE ON CRAWFORD W. LONG MEMORIAL. The Committee on Crawford W. Long Memorial shall supervise matters pertaining to the Crawford W. Long Memorial and shall represent the Association in such matters subject to the approval of Council.

(T) COMMITTEE ON MENTAL HEALTH. The Committee on Mental Health shall promote the welfare of the mentally ill in the state of Georgia and shall constantly seek means of improving care for the mentally ill in the state.

Now Reads:

CHAPTER XI.

The Journal

Sec. 1. The Journal of the Medical Association of Georgia herein referred to as The Journal, shall be under the control and direction of the Council. It shall appoint an Editor, and an Editorial Board and make any other provisions for the publication of The Journal which in its judgment are necessary. Such appointee or appointees shall serve at the pleasure of the Council, which shall have full discretionary power to promulgate rules and regulations governing the publication of The Journal; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

Sec. 2. The Council may employ a Business Manager of The Journal and other personnel and fix the terms of such employment.

Sec. 3. All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in The Journal. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

Will Read:

CHAPTER XI.

The Journal

SEC. 1. THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA herein referred to as THE JOURNAL, shall be under the control and direction of the Council. It shall appoint an Editor and an Editorial Board and make any other provisions for the publication of THE JOURNAL; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SEC. 2. The Council may employ a Business Manager of THE JOURNAL and other personnel and fix the terms of such employment.

SEC. 3. All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in THE JOURNAL. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

SEC. 4. The Executive Committee of the Council shall constitute the Publications Committee of THE JOURNAL.

Lung Operation on TV

TO PUT OVER A PROJECT such as the recent television "Operation Lung Cancer" it takes the cooperation and teamwork of many people. The whole story will be in the May issue of the *Bulletin of the Fulton County Medical Society*; its author is the man whose became reality, A. Hamblin Letton, Atlanta. Sponsors for the program were the Fulton County Medical Society, Georgia Division of the American Cancer Society, Greater Atlanta's Red Cross Blood Bank, the Atlanta Tuberculosis Association and last but not by any means least—WSB-TV.

The hospital—Georgia Baptist—was chosen because the television engineers found that they could get a better signal from their remote truck when it was stationed there than at any other hospital in town. The touchy problem of who would operate was partially solved when it was discovered that Richard King and

M. Bedford Davis, Atlanta, are the only Georgia Baptist Hospital staff members doing chest work exclusively. WSB-TV notified Dr. Letton that they would cancel the "Medic" program on either March 28, 1955, or April 11th, whichever suited for this "Operation Lung Cancer." Dr. Davis found the patient, Mr. Murphy, the week before the 28th of March, and he is the physician who performed the operation.

Mr. Taylor Lumpkin was assigned to produce and direct the program; he reworded and rearranged the script by Dr. Letton. Mr. Alva Lines of Southeastern Film shot the background scenes, with technical assistance from Dr. Letton.

The following men participated in the panel discussion, moderated by Mr. Ray Moore, from the studio: McLaren Johnson, Milton Freedman, C. C. Aven, William A. Hopkins and Mr. Arthur Montgomery.

ANNOUNCEMENTS

American College of Chest Physicians 21st Annual Meeting—June 1-5, 1955, Ambassador Hotel, Atlantic City, N. J. The scientific program will include approximately 200 speakers. Fellowship examinations will be held on June 2, and Fellowship certificates will be presented at the annual Convocation which will precede the Presidents' Banquet on June 4. All physicians are invited; there is no registration fee. For information write to the Executive Offices, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Illinois.

A recent copy of the semi-annual bi-lingual *Hebrew Medical Journal* has been received in the *Journal* office. Besides the usual sections on medical subjects "Israel and Health", "Talmudic Medicine", "Old Hebrew Manuscripts", this issue contains a special section in Maimonides, the renowned Jewish medieval physician and philosopher, in commemoration of the 750th anniversary of his death.

Eight Week Comprehensive Course in Industrial Medicine—beginning September 26, 1955, Post-Graduate Medical School of New York University-Bellevue Medical Center, New York City. Among the subjects offered are: organization, administration and economics of an industrial medical department; the practice of preventive and constructive medicine in industry; the clinical aspects of occupational diseases; industrial injuries and the elements of safety programs; and toxicology and industrial hygiene for the physician. Applications should be sent to the Dean, NYU Post-Graduate Medical School, New York 16, N. Y. Tuition \$250.00.

Southern Pediatric Seminar—July 11-30, 1955, Saluda, North Carolina. The course will be divided into three one-week sessions; the first two sessions will be devoted to pediatrics and internal medicine, the third week will be given over to obstetrics and gynecology. The seminar is accredited by the American Academy of General Practice for post-graduate instruction. For further information write to Dr. D. L. Smith, Registrar, 187 Oakland Ave., Spartanburg, S. C.

American Proctologic Society 54th Annual Meeting—June 1-4, 1955, Hotel Statler, New York, N. Y. For further information write to W. W. Green, M.D., Chairman, Committee on Public Relations, 201 Professional Bldg., Toledo, Ohio.

10th Annual Schering Award for Medical Students.—Titles of three subjects on which American and Canadian students are invited to submit papers this year are: Current Concepts in the Management of Osteoporosis; Prevention and Treatment of Blood Transfusion Reactions; and Recent Trends in the Clinical Use of Adrenocortical Steroids. A \$500 first prize and a \$250 second prize will be awarded for each of the three subjects. Deadline for entry forms specifying the choice of title is July 1, 1955. Manuscripts must be mailed not later than October 1, 1955. Information and instructions for the award competition are available from the Schering Award Committee, 60 Orange St., Bloomfield, N. J.

Short Course in the Clinical Pathology and Pathology of Parasitic Diseases—August 15-17, 1955, Louisiana State University School of Medicine, New Orleans, La. The fee for the course is \$50.00. For further information write to Dr. Clyde Swartzwelder, Dept. of Microbiology, L. S. U. School of Medicine, 1542 Tulane Ave., New Orleans 12, La.

American Congress of Physical Medicine and Rehabilitation Annual Essay Award—The contest is open to anyone; the winner shall receive a cash award of \$200, a gold medal, certificate of award and an invitation to present the paper at the 33rd Annual Session of the American Congress of Physical Medicine and Rehabilitation (see below). All inquiries should be addressed to the American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Ill.

DEATHS

FREDERICK NOBLE ALDRICH, Macon, died on February 25, 1955, at the age of 69. He was a native of Glover, Vermont, and a graduate of the Vermont University School of Medicine. Dr. Aldrich did post-graduate work in a number of universities in this country, Canada and France. He served with the U. S. Army in the First World War, attaining the rank of major.

Dr. Aldrich practiced for a number of years in Brunswick before coming to Macon 19 years ago. He was a past president of the Eye, Ear, Nose and Throat Society of Georgia and a member of the Methodist Church.

Funeral services were held February 27, 1955, at the Vineville Baptist Church. Among the pallbearers were Robert W. Edenfield, Macon, and J. Lon King, Jr., Macon. Members of the Bibb County Medical Society served as honorary pallbearers.

Dr. Aldrich is survived by his wife, Mrs. Bernice Colby Aldrich; two sons, Mr. W. C. Aldrich, of Hiassee, and Mr. F. N. Aldrich, Jr., of Houston, Texas.

DONALD LEROY BUTTERFIELD, Dalton, died on March 22, 1955, after a short illness. Dr. Butterfield was 51 years old.

A native of Ohio, Dr. Butterfield first came to Georgia in 1941 when he was assigned to Fort Benning with the U. S. Army Medical Corps; later he was stationed at Camp Gordon. He served three years overseas in the European Theatre and returned to Georgia to practice after his discharge in 1945. Dr. Butterfield set up private practice in Waynesboro and later was with the health department in Waynesboro, serving as commissioner of health of Burke-Screven-Jenkins Counties. He went to Dalton last September where he was commissioner of public health of the Dalton-Whitfield and Chatsworth-Murray health departments.

His wife, Mrs. Louise Wileman Butterfield, R.N., is one of the nurse supervisors at Hamilton Memorial Hospital. Other survivors include a son, Mr. David Allyn Butterfield, with the U. S. Navy at San Diego, and a brother, Billy Butterfield, Long Island, N. Y.

Funeral services were held on February 24, 1955, at the Dalton First Methodist Church, with burial in Iron-ton, Ohio. Members of the Whitfield County Medical Society and the health departments of Whitfield and Murray Counties were honorary pallbearers.

THOMAS JACKSON CHARLTON, Savannah, died February 27, 1955, after a long illness. Dr. Charlton was born in Savannah on April 19, 1895, the son of the late Dr. Thomas J. Charlton and Mrs. Charlton, the former Miss Wilhelmina Howell. He was educated at Episcopal High School, Alexandria, Va., Yale University and Yale Medical School.

During World War I, Dr. Charlton served as a lieutenant with the 49th Field Artillery, and in World War II, he served as a lieutenant colonel in the Philippines. Dr. Charlton was a past governor of the Society of Colonial Wars, a member of the Sons of Cincinnati, a member of the Oglethorpe Club and a vestryman of Christ Episcopal Church. He served for some time as president of the Georgia Infirmary, an institution to which he gave generously of his time, his energy and his professional services.

He is survived by a daughter, Mrs. Maxwell W. Lippitt, Jr., Atlanta; two sons, Mr. Thomas Charlton and Mr. Read Charlton, both students at Yale University; and one grandson. Mrs. Charlton, the former Anne Carrington Read, died in 1948.

Funeral services were held at the residence on March 1, 1955, with the Reverend F. Bland Tucker, D.D., rector of Christ Church, and the Right Reverend Middleton S. Barnwell, D.D., retired bishop of the Diocese of Georgia, officiating. Burial was in Bonaventure Cemetery. Honorary pallbearers included A. T. Waring, Jr., Lawrence Lee, Jr., John Howkins and Lawrence Dunn, all of Savannah.

LINTON Gerdine, Athens, died March 3, 1955, at the age of 64. Son of the late Dr. and Mrs. John Gerdine, he was a lifelong resident of Athens. He was educated in the public schools of Athens and graduated from the University of Georgia with a B.S. degree. He received his M.D. degree from Johns Hopkins University in 1913.

Dr. Gerdine was a veteran of both world wars, serving as a lieutenant in the Navy Medical Corps in World War I, and as a captain in the Naval Reserve in World War II. He was a member of the First Presbyterian Church, the Masons, American Legion and Forty and Eight. Dr. Gerdine was a fellow in the American College of Physicians and a member of the Georgia Pediatrics Society. He served for a number of years as chairman of the Athens-Clarke County Board of Health.

Funeral services were conducted on March 4, 1955, at the graveside in Oconee Hill Cemetery.

JOHN KIRK TRAIN, SR., Savannah, died after a long illness on March 15, 1955. He was 75 years old. Dr. Train was born in Savannah on February 12, 1880; he attended the Savannah public schools and the University of Virginia. He was graduated from the University of Virginia School of Medicine in 1899 and took additional work at the College of Physicians and Surgeons at Columbia University.

Dr. Train was a past president of the Georgia Medical Society, past president of the St. Andrew's Society and a vestryman and former senior warden of St. John's Episcopal Church. He was several times elected president of the Savannah Alumni of Virginia, and in 1939 was named honorary president. He was for several years vice-president of the Savannah Community Chest.

He had been chief surgeon for Union Bag and Paper Corporation and for the Savannah and Atlanta Railroad, assistant surgeon of the Central of Georgia Railroad for 25 years, and a member of the staffs of the following hospitals: Central of Georgia, Telfair, Georgia Infirmary, Charity and St. Joseph's.

Immediate survivors include his wife, Mrs. Lilla Comer Train; three daughters, Mrs. S. L. Varnedoe, Mrs. Lawton M. Calhoun and Mrs. Harriet T. Blake, all of Savannah; three sons, John K. Train, Jr., Savannah, Mr. Robert Train, Macon, and Mr. H. M. Comer Train, Mobile, Ala.

Funeral services held on March 16, 1955, at St. John's Episcopal Church were conducted by the rector, the Reverend Ernest Risley; the Right Reverend Middleton S. Barnwell, D.D., retired bishop of the Diocese of Georgia; and the Right Reverend C. C. J. Carpenter, D.D., bishop of the Diocese of Alabama and a former rector of St. John's Church. Burial was in Bonaventure Cemetery. Serving as honorary pallbearers were J. C. Metts, G. H. Lang, J. K. Quattlebaum, T. A. McGoldrick, C. L. Prince, P. L. Scardino, J. F. Chisholm, Robert Drane, Jabez Jones, William Dancy, Fulmer Holton and St. Julian deCaradeuc.

A. D. WARE, Toombsboro, died March 8, 1955, in a Milledgeville hospital. Dr. Ware, a Life Member of the Medical Association of Georgia, was 68 years old.

A native of Marshallville, Dr. Ware came to Toombsboro as a young man; there he practiced for over 40 years.

Besides his active medical practice, Dr. Ware was a deacon of the Baptist Church, a bank director and a school trustee.

Survivors include his wife; two sons, Mr. A. D. Ware, Jr., Macon, and Mr. Clyde D. Ware, St. Petersburg, Fla.; and one daughter, Mrs. Frank J. Garbutt, Sandersville.

Funeral services were held on March 9, 1955, at the First Baptist Church of Toombsboro, with interment in the Marshallville Cemetery.

SOCIETIES

The SEVENTH DISTRICT MEDICAL SOCIETY met on April 6, 1955, at Callier Spring Club in Rome for a business session, reading of scientific papers and a social outing. The address of welcome was given by Emmett S. Brannon, Rome, president of the Floyd County Medical Society. Father Patrick C. Connell, St. Mary's Roman Catholic Church, gave the invocation. Scientific papers and discussions during the afternoon included: "Cancer of the Urinary Bladder" by Jack M. Waldrep, Rome, discussion by Robert M. Harbin and J. L. Garrard, Rome; "Errors in Diagnosis and Treatment of Heart Disease", by R. Bruce Logue, Emory University, discussion by Ray Spanjer, Cedartown, and Lester Martens, Rome; "Herpangina" by Harold J. Starr, Chattanooga, discussion by Ralph Fowler, Marietta, and Stephen Smith, Rome; "Endometriosis" by Hobart Hortman, Rome, discussion by Lester Harbin, Rome, and W. U. Hyden, Trion. A barbecue at 6:00 p. m. concluded the session.

The EIGHTH DISTRICT MEDICAL SOCIETY met on April 12, 1955, at the Country Club, Valdosta. The

scientific session followed the call to order by the president, Van B. Bennett, Valdosta, and invocation, given by the Reverend James P. Rogers, pastor of the First Baptist Church of Valdosta. The following physicians participated in the scientific program: J. H. Brannen, Valdosta—"Traumatic Urology"; L. K. Newlin, Valdosta—"Practical Points in Pediatric Diagnosis"; and R. K. Winston, Valdosta—"Treatment of Traumatic Lesions of the Eye." Business session, social hour and dinner completed the program.

The NINTH DISTRICT MEDICAL SOCIETY held its Spring Convention in Toccoa on April 20, 1955; president Alex B. Russell, Winder, presided. The Reverend D. Cullen Jones, Toccoa, gave the invocation and William H. Good, Toccoa, the address of welcome. J. L. Walker, Clarkesville, read a report of the Maternal and Infant Welfare Committee of the MAG in the Ninth District, and P. K. Dixon, Gainesville, spoke on "Pyloric Stenosis". Rudolf J. Noer, Professor of Surgery at the University of Louisville, spoke on "The Treatment of Chest Injuries"; Hamil Murray, Gainesville, pathologist at the Hall County Hospital, presided at a clinical pathological conference, and Samuel D. Hay, Toccoa, discussed the case. The business session followed the scientific session. The Stephens County Medical Society was host at a social hour preceding dinner at the Toccoa Country Club.

The quarterly dinner meeting of the BARTOW COUNTY MEDICAL SOCIETY was held March 9, 1955, at Dock Adams in Cartersville. Guest speaker at this meeting was David Henry Poer, Atlanta, secretary-treasurer of the MAG. The subject of his address was "Diseases of the Thyroid". J. W. Stanford, Cartersville, presided in the absence of the president, W. E. Wofford, Cartersville.

At the February meeting of the BLUE RIDGE MEDICAL SOCIETY the following officers for 1955 were elected: president, James Burdine, Ellijay; vice-president, R. A. Burns, Blue Ridge; secretary, Thomas J. Hicks, McCaysville, who was elected for his tenth consecutive term. C. C. Brooks, Blue Ridge; H. P. Hyde, McCaysville; and Thomas J. Hicks, McCaysville, were elected censors.

The CARROLL-DOUGLAS-HARALSON MEDICAL SOCIETY held its monthly dinner meeting on March 7, 1955, at Rock Inn in Douglas County. Donald Cathcart, Atlanta, was guest speaker. The April meeting was held at Tanner Memorial Hospital in Carrollton on April 4, 1955.

FLOYD COUNTY MEDICAL SOCIETY has elected the following officers to serve during the year 1955: president, Emmett S. Brannon, Rome; president-elect, Clarence J. Sapp, Rome; and secretary-treasurer, J. S. Garner, Jr., Rome.

The FORSYTH COUNTY MEDICAL SOCIETY voted to merge with the GWINNETT COUNTY MEDICAL SOCIETY at a meeting on January 30th. Officers elected to serve until the merger is effected are as follows: president, Rupert Bramblett, Cumming, and secretary, James S. Mashburn, Cumming.

The regular monthly meeting of the HABERSHAM COUNTY MEDICAL SOCIETY was held at the Commercial

Hotel in Cornelia on March 3, 1955. The meeting was preceded by the usual "Dutch treat" dinner with the Woman's Auxiliary. The scientific program was presented by Martin Smith, Gainesville, who spoke on "Thrombocytopenic Purpura".

The quarterly meeting of the LAURENS COUNTY MEDICAL SOCIETY was held on March 24, 1955, at the Dublin Country Club. A neuro-surgical program was given with short talks by Juan E. Fonseca, of the Dublin Veterans Administration Hospital, and Robert A. Clark, Macon.

Ernest C. Brown, Baltimore physician and instructor in medicine at Johns Hopkins, spoke to the RICHMOND COUNTY MEDICAL SOCIETY on March 22, 1955. His subject was "Recent Trends in Treatment of Diabetes Mellitus"; he pictured in detail new types of insulin that have been used for some time in Denmark and are now in use at Johns Hopkins. The society approved by unanimous vote the proposed mass use of polio vaccine in the Augusta area and agreed to work with the Health Board in formulating plans for innoculating children when the signal to proceed is given by the National Polio Foundation.

STEPHENS COUNTY MEDICAL SOCIETY met on February 21, 1955, and elected the following officers for 1955: president, William H. Good; vice-president, S. L. Harp; secretary-treasurer, Clarence L. Ayers; and censors, A. G. Singer, Henry H. McNeely and Robert E. Shiftlet, all of Toccoa.

The THOMAS COUNTY MEDICAL SOCIETY held its quarterly meeting on March 17, 1955. Guest speakers at the meeting were Willard H. Parsons, of Vicksburg, Miss., chairman of the Board of Directors of the American College of Surgeons, and H. Luten Teate, Jr., Atlanta. The subject of Dr. Parsons' talk was "The Surgery of the Elderly"; Dr. Teate's subject was "Clinical Aspects of the Rh Factor". Dinner with the Woman's Auxiliary at the Glen Arven Country club followed the scientific session.

WAYNE COUNTY MEDICAL SOCIETY met on March 14, 1955, and elected the following officers for the year: president, Robert A. Pumpelly, Jesup; vice-president, J. A. Leaphart, Jesup; and Daniel H. G. Glover, Jesup, was elected secretary-treasurer.

PERSONALS

First District

Doctors' Day in Savannah was celebrated with a formal dinner dance given by the Woman's Auxiliary to the Georgia Medical Society at the General Oglethorpe Hotel. Mrs. Fenwick Nichols was general chairman. Decorations featured red carnations, the Doctors' Day flower, and each doctor was presented a red carnation boutonniere.

The Georgia Society of Ophthalmology and Otolaryngology held its annual two-day convention in Savannah March 11 and 12, 1955. Featured speakers were Francis Heed Adler, Philadelphia; James H. Allen, New Orleans; Walter H. Fink, Minneapolis; Jerome A. Hilger, St. Paul; J. W. McCall, Cleveland; and P. E. Ireland, Toronto.

The Savannah Surgical Society heard an illustrated discussion on modern treatment of abnormalities of the genito-urinary tract on March 3rd. Speakers were Donald Smith, of the University of California, and F. E. B. Foley, St. Paul.

The 35th Annual Meeting of the Medical and Surgical Section of the Association of American Railroads met at the General Oglethorpe Hotel in Savannah March 25 and 26th. More than 100 chief surgeons attended the sessions. C. F. HOLTON, Savannah, chief surgeon of the Central of Georgia Railroad, was in charge of arrangements for the meeting. Among the speakers was SAMUEL F. ROSEN, Savannah, whose address was entitled "Chromium Compounds as Industrial Hazards". Dr. Holton was elected to the Committee of Direction for the coming year.

JULIAN F. CHISHOLM, SR., Savannah, has retired from active practice because of ill health. Dr. Chisholm has practiced medicine nearly 53 years, and during this time has ministered to the eye, ear, nose and throat ailments of thousands of patients. He graduated from the University of Maryland Medical School and did post-graduate work at the Presbyterian Ear, Eye, Nose and Throat Hospital in Baltimore and Johns Hopkins Hospital. He started practicing in Savannah in 1902 and has been in practice there since then with the exception of the time spent in the U. S. Army Medical Corps in World War I. He is a fellow in the Rush Medical Society, a member of the American College of Surgeons and the Georgia Ophthalmological Society, of which he is a past president.

Lamon E. Danzig, Savannah, announces the opening of an office for the practice of internal medicine. He is occupying the suite of offices formerly occupied by the late J. REID BRODERICK at 125 East Jones Street. A native of South Carolina, Dr. Danzig took his pre-medical training at The Citadel, and he received his M.D. degree from the Medical College of South Carolina in Charleston in 1947. He has recently completed a tour of duty in the Army Medical Corps serving as chief internist with an Army research unit at Brooke Army Hospital, Fort Sam Houston, Texas.

MARVIN F. ENGEL, Darien, was beginning to think he was jinxed after attending the birth of nothing but boys since he began his practice in Darien in December 1953. But the spell was broken in March when one of his patients gave birth to a bouncing baby girl.

IRVING VICTOR, Savannah, announces the association in the practice of urology with him of Frederick M. Jacobs, formerly of Memphis, Tenn. Dr. Jacobs is a native of Roanoke, Va., a graduate of the University of Virginia and the University of Virginia School of Medicine. He interned at the Long Island College of Medicine Hospital, following which he took residencies in surgery and urology there. He served with the U. S. Army Medical Corps from 1940 to 1946. Upon return to inactive duty in June 1946, he accepted the position as chief of urology at the newly organized V. A. Medical Teaching Group, Kennedy Hospital, Memphis. It was here that Dr. Victor met Dr. Jacobs; Dr. Victor was stationed at Kennedy Hospital on detached service with the Navy. Dr. Jacobs was recalled to active duty

with the Army in 1950 and served until 1953 when he returned to private practice in Memphis. He is a diplomate of the American Board of Urology, fellow of the American College of Surgeons, fellow of the International College of Surgeons, fellow of the American Geriatrics Society and a member of the Tennessee Chapter of the American College of Surgeons. Dr. Jacobs is married to the former Margaret Dallas of Memphis.

Devereux Lippitt, Savannah, has opened a laboratory for the practice of clinical pathology at 101 East Huntingdon Street. Dr. Lippitt attended Princeton University and received his M.D. degree from Harvard Medical School in 1947. He interned in medicine at the Cornell Division of Bellevue Hospital and took post graduate courses in medicine and was house physician at the British Post Graduate Medical School in London.

W. C. MCCARVER, Vidette, was honored recently for his service to the Vidette community as a doctor and citizen. Dr. McCarver, because of a recent illness, was unable to attend the dinner given in his honor and to receive there the silver tray presented by the people of Vidette. In addition to his practice, Dr. McCarver has found time to serve as town mayor for 20 years and to serve on the school board and the Burke County Board of Education for 22 years. He has been president of the Farmer's Bank of Vidette for several years and on the Board of Stewards of the Methodist Church. Dr. and Mrs. McCarver have two sons, W. C. MCCARVER, JR., Gainesville, and the Reverend Clyde G. McCarver of Wilmington, N. C.

J. C. METTS, Savannah, was the principal speaker at the dinner honoring the past presidents of the Georgia Medical Society in March. Dr. Metts gave his philosophy on the practice of medicine in a paper entitled "This I Believe". RUSKIN KING, Savannah, was toastmaster for the affair and introduced the following past presidents of the society: WILLIAM A. COLE, E. C. DEMMOND, ROBERT DRANE, L. B. DUNN, W. R. DANCY, M. J. EGAN, J. L. ELLIOTT, M. J. EPTING, G. H. FAGGART, L. M. FREEDMAN, E. N. GLEATON, LEE HOWARD, SR., C. F. HOLTON, W. V. LONG, G. H. LANG, H. L. LEVINGTON, P. V. MARTIN, J. C. METTS, H. J. MORRISON, J. H. PINHOLSTER, J. K. QUATTLEBAUM, H. Y. RIGHTON, CHARLES USHER and the late J. K. TRAIN.

PETER L. SCARDINO, Savannah, who is chairman of the Georgia Medical Society's Public Relations Committee, addressed the Fifth Annual County Medical Society Officers Conference held in Lexington, Ky., April 7, 1955. The topic of his address was "The Case for Social Medicine."

RUTH MOYER WARING, Savannah, has been made a fellow of the American Academy of Orthopedic Surgeons. Other members of the Academy in Savannah are T. P. WARING and F. BERT BROWN.

Second District

Doctors' Day, March 30th, was celebrated in Albany with a dinner at Sandy Beach sponsored by the Woman's Auxiliary to the Dougherty County Medical Society.

JAMES E. CANTRELL, Albany, announces the removal of his offices to the Professional Building, 121 Oglethorpe Avenue.

R. C. RICHARDSON, Albany, attended the recent meeting of the Georgia Society of Ophthalmology and Otolaryngology at the General Oglethorpe Hotel, Savannah.

W. P. RHYNE, Albany, was elected secretary-treasurer of the Georgia Society of Ophthalmology and Otolaryngology at the recent Spring meeting held in Savannah.

The *Journal* regrets to announce the death of Mr. Philip E. Roberson, father of PHIL E. ROBERSON, Albany, on March 16, 1955.

Third District

OTHA K. COLEMAN, Vienna, and Mrs. Coleman have moved to Cordele to make their home. Dr. Coleman has moved into his newly constructed office building in the downtown section. Dr. Coleman graduated from the Medical College of Georgia and came to Vienna in 1948 to practice.

BON M. DURHAM, Americus, left on March 29th for two months study of internal medicine at the University of Vienna, Austria, where he will also work in the University hospital. Mrs. Durham and the children will remain in Americus while he is away.

R. C. PENDERGRASS, Americus, was the speaker at a recent meeting of the Kiwanis Club of Thomaston. ENOCH CALLAWAY, LaGrange, addressed the Lions Club of Thomaston the day before. These talks were in connection with the Cancer Drive, and the physicians spoke on behalf of the Georgia Division of the American Cancer Society.

W. D. WILCOX, Fitzgerald, has resumed his practice after an illness of several months.

SAMUEL P. WISE, III, formerly of Americus, son of B. T. WISE, Plans, has been accepted as a certified diplomate of the American Board of Internal Medicine. He is now associated with the Casey Clinic in San Benito, Texas.

Fourth District

No news received.

Fifth District

Doctors' Day was celebrated in Atlanta with a social hour and seated dinner at the Progressive Club. The theme of the party was "Down Mexico Way" and the music was supplied by an orchestra colorfully dressed in Mexican costumes, a group from the Atlanta Civic Ballet danced the native dances, and Dr. and Mrs. WILLIAM A. SMITH were the winners of the prize trip to Mexico. Mrs. William A. Hopkins was general chairman of arrangements for the party.

JAMES R. CAIN, Atlanta, has been appointed associate pathologist at Grady Memorial Hospital, Atlanta. A native of Charleston, S. C., Dr. Cain received his medical training at the Medical College of South Carolina. More recently, he was assistant pathologist at Crawford W. Long Memorial Hospital. Dr. and Mrs. Cain and their three children live at 898 Kings Court, N. E.

RIVES CHALMERS, Atlanta, was the principal speaker at the March meeting of the Atlanta Chapter of the Georgia Association for the Help of Retarded Children.

G. THOMAS COWART, Atlanta, now associated in practice with M. K. BAILEY, has been certified as a diplomate of the American Board of Urology.

CHARLES L. DAVIS, Atlanta, has recently moved to Roswell and is temporarily located on the main floor of the old Masonic Hall Building. Dr. Davis is a native Georgian, a graduate of Mercer University and the Medical College of Georgia. He interned at Wilmington General Hospital, Wilmington, Del., and served in the U. S. Navy. After his release from the Navy he completed one year of surgical residency in Los Angeles and practiced there from 1946 to 1954 when he came to Atlanta.

LEILA D. DENMARK, Atlanta, addressed the congregation of the Acworth Methodist Church on February 27th; her topic was "The Child in the Home".

ROGER W. DICKSON, Atlanta, addressed the Cartersville Chapter, Georgia Association for the Help of Retarded Children, on Tuesday evening, April 19th, at the First Presbyterian Church in Cartersville.

MURDOCK EQUEN, Atlanta, was recently presented a Lifetime membership in the Georgia Association of Laryngectomees, Inc. The scroll conferring the membership said, "The Georgia Association of Laryngectomees, Inc., acknowledges with grateful appreciation the thoughtful kindnesses and services rendered for the Association and its membership by Dr. Murdock Equen, a true friend and surgeon who has done much to help the organization, and in appreciation thereof, the Association presents this scroll conferring a Lifetime Membership."

BRIT B. GAY, JR., Emory University, has been promoted from associate in radiology to assistant professor of radiology in the Emory University School of Medicine. WILLIAM F. VAN FLEIT, was elevated from instructor in surgery to associate in surgery. Added to the medical school faculty on a voluntary basis were ALBERT FISHER, FOREST D. JONES and MARGARET M. KUGLER. Physicians reappointed after leaves of absence were JOHN J. BARNES, FRANCIS W. FITZHUGH, JR., and SEYMOUR P. WEINBERG.

IRVING L. GREENBERG, Atlanta, has been accredited as a diplomate of the American Board of Surgery. Dr. Greenberg was also the principal speaker at the first report meeting of the Employees Division of the 1955 Greater Atlanta Red Cross campaign held on March 22, 1955.

ALTON V. HALLUM, Atlanta, was elected president of the Georgia Society of Ophthalmology and Otolaryngology at the recent meeting of the society held in Savannah.

WILLIAM A. HOPKINS, Atlanta, announces the removal of his offices to Suite 735, Cyrus W. Strickler, Sr. Doctors Building, 1293 Peachtree St., N. E., for the practice of thoracic surgery, cardio-vascular surgery and broncho-esophagology.

CHRISTOPHER J. McLoughlin, Atlanta, was guest speaker at the March 8th meeting of the Canton Rotary Club. He described the rise of medicine from the very earliest times to the present.

LESTER RUMBLE, JR., Atlanta, spoke to some 125 nurse anesthetists who had gathered in Atlanta for a five day anesthetist institute. He urged the nurses to

use what he termed the "proper psychology" and let the patient know what to expect from an operation.

FLOYD R. SANDERS, JR., Decatur, announces his return from active duty with the U. S. Navy and the reopening of his office at 603 Church Street for the practice of general medicine.

JOEL P. SMITH, Atlanta, having completed two years of military service, announces the reopening of his offices at 26 Linden Avenue, N. E., with practice limited to diseases of the eye, ear, nose and throat.

JOHN E. TAYLOR, Decatur, announces the association of George W. Statham and the removal of offices to 341 West Ponce de Leon Avenue across the street. Their practice is limited to pediatrics.

H. LUTEN TEATE, JR., was the guest speaker at a recent meeting of the Thomas County Medical Society in Thomasville. Mrs. Teate and their children, Chip, Mike, Susan and Nancy, went with Dr. Teate to Thomasville and were the guests of his parents, Mr. and Mrs. H. L. Teate, Sr.

Sixth District

The Woman's Auxiliary to the Bibb County Medical Society gave a party for the Macon doctors to celebrate Doctors' Day, March 30th. The affair was held at the American Legion Clubhouse with social hour from 7:00 to 8:00 p. m., followed by dinner and dancing. The Doctors' Day committee of the auxiliary included Mrs. John Paul Jones, chairman, Mrs. Edmund Brannon, Mrs. Rudolph Jones, Jr., and Mrs. E. C. McMillan, Jr.

W. L. BARTON, Macon, was elected vice-president of the Georgia Society of Ophthalmology and Otolaryngology at the recent meeting in Savannah.

The *Journal* regrets to announce the death on February 20, 1955, of Mrs. O. D. Lennard, wife of O. D. LENNARD of Tennille, president of the Washington County Medical Society.

N. J. NEWSOM, Sandersville, has resigned as Washington County's health officer. F. T. McELREATH, JR., Tennille, has been named county physician to succeed Dr. Newsom.

Seventh District

A Doctors' Day dinner was given in Calhoun at the home of Dr. and Mrs. CHARLES K. RICHARDS by the Woman's Auxiliary to the Gordon County Medical Society. Approximately 16 physicians, their wives and guests, attended the affair.

Groundwork on an \$85,000 Medical Arts Building was started in February at 1205 Roswell Street in Marietta. ALFRED O. COLQUITT, JR., is owner. The building will contain 7,800 square feet of space and will include suites for four doctors and two dentists, an apothecary shop, X-ray and diagnostic laboratory.

Eighth District

W. M. RETTERBUSH, Valdosta, was the principal speaker for the Valdosta Association of Life Underwriters at a recent luncheon meeting.

FOWLER F. WHITE, who has practiced medicine in Baxley for nearly two years, announced that he was closing his office on March 26 to accept a position with United Aircraft Corporation in Hartford, Conn. He

assumed his new duties on April 1st.

Ninth District

The Cherokee-Pickens Medical Society members were honored on Doctors' Day by the society's auxiliary at a dinner at Pine Crest in Canton. On the Sunday preceding flowers were placed in the First Methodist Church and the First Baptist Church of Canton in tribute to all the doctors who have ever practiced medicine in the area.

JOE J. ARRENDALE, Cornelia, attended the recent meeting of the Board of Directors of the Georgia Academy of General Practice held at the Biltmore Hotel in Atlanta. He also attended the meeting of the American Academy of General Practice in Los Angeles in March.

CHARLES M. HENRY, Clarkesville, announces the removal of his office from the Reeves Building to the Habersham Medical Building. J. L. WALKER and L. G. HICKS, JR. already have their offices in that building. The building was formerly the Presbyterian manse.

GEORGE T. NICHOLSON, Cornelia, has been made a member of the staff of the *Georgia General Practitioner*; he will be the News Notes editor. Dr. Nicholson has been in the news elsewhere; he was among more than 600 persons attending the 10th national Rural Health Conference held in Milwaukee February 24-26, 1955.

Tenth District

A city of Augusta building permit has been issued for a doctors' office building to be erected on 15th Street south of Gwinnett. The 30x104 foot brick and concrete block structure will be built for GEORGE F. McINNES.

EDGAR R. PUND, Augusta, was guest speaker at a recent meeting of the Harlem Rotary Club. He gave a talk on the objectives and organization of the Medical College of Georgia. He was introduced by RICHARD TORPIN, professor of obstetrics and gynecology at the Medical College.

HOKE WAMMOCK, Augusta, was the principal speaker at the March 23rd meeting of the Waynesboro Rotary Club. He spoke on cancer research.

News from the Southern Medical Association

The mail on April 1 contained individual invitations to Georgia physicians urging them to attend the Houston Meeting, November 14 to 17, 1955. The letter was under the signature of James L. Pittman, President of the Harris County Medical Society.

The Houston Committee on arrangements for the meeting is the largest and most comprehensive one ever established, comprising 32 groups of host physicians and their wives. Indeed, every section of the Southern will have an individual *host committee*. In addition to the festive activities, those attending the convention will have a chance to visit and inspect the \$100,000,000 Texas Medical Center, which is one of the finest centers of its kind in the world.

The home office under Mr. V. O. Foster and the business manager, Robert F. Butts, is leaving no stones unturned in trying to get a large attendance and a fine exhibit at the meeting. Mr. C. P. Loran, is lending his hand also. The Houston Meeting is shaping up fast to be the best one of the Southern Medical gatherings in many, many years: *On to Houston!*

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1955 by the Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; 1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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The cover picture by Miss Kathleen Mackay and Ted F. Leigh, M.D., symbolizes the recent progress in polio research made possible by the March of Dimes and other research funds. Also see "Editorials, page 233".

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The Injured Ankle

WOOD W. LOVELL, M.D., and RICHARD E. KING, M.D., Atlanta, Ga.

INJURIES OF THE ankle are quite common and often result in a period of prolonged disability. This is particularly true if the injury is not correctly diagnosed. The authors have seen numerous instances of this and therefore wish to stress the necessity of an accurate appraisal of a patient with a history of acute trauma involving the ankle. All too often he is told that he has a sprain and to return home and to "soak the ankle."

Anatomy of the Ankle

The ankle is a hinge joint. It is formed by the lower end of the tibia and its malleolus and the malleolus of the fibula and the talus. The lower end of the tibia and fibula is held by the interosseus ligament. In addition to the capsule which surrounds the joint, there is a very strong triangular ligament on the medial aspect. This is known as the deltoid ligament or the medial collateral ligament. The lateral collateral ligament supports it on its outer aspect. The deltoid ligament is attached to the apex of the medial malleolus above, and below it assumes the shape of a fan to attach to the navicular, the sustentaculum tali of the calcaneus and the neck and body of the talus. The lateral collateral ligament consists of three portions: the anterior talo-fibular ligament, the posterior talo-fibular ligament and the calcaneo-fibular ligament. These ligaments are of great importance and are frequently injured. The talus is normally held in a vertical position and is prevented from tilting either medially or laterally by the mortise of the ankle joint. The mortise of the ankle joint is formed by the lower articular surface of the tibia and the two malleoli.

Classification

There are many classifications. A simple but inclusive classification is as follows:

1. A simple sprain
2. A tilted talus
3. A widening of the mortise
4. A fracture and/or dislocation

Simple Sprain

By definition, a sprain denotes a tearing of the supporting ligaments. The collateral ligaments serve principally to support the ankle medially and laterally and, in doing so, restrict motions in these directions. Most sprains involve the lateral collateral ligament, particularly the anterior portion, and result from an inversion stress of the ankle. The ankle is swollen and weight-bearing is painful. The swelling is usually confined to the anterior and lateral portion of the ankle. There may be tenderness over the attachment of the anterior talofibular ligament. Flexion and extension of the ankle may be normal, but forced inversion is extremely painful. In addition to the routine antero-posterior and lateral radiographs, one should make inversion and eversion stress films. Treatment consists of early mobilization and weight-bearing as soon as tolerated: This is insisted upon because there is no widening of the mortise or tilting of the talus as the continuity of the supporting ligaments is not unduly disturbed. It is sometimes advisable to use crutches for a few days. The swelling is combatted by elevation, ice packs and an elastic bandage.

Tilted Talus

As mentioned above the talus fits rather closely between the malleoli and the articular surface of the lower tibia. If the abduction force is strong enough, the lateral collateral ligament will be torn. A strong adduction injury will result in tearing of the deltoid ligament. However, the lateral collateral ligament is more frequently torn. In order to demonstrate the tearing of the ligament with subsequent tilting of the talus, one must make stress radiographs. It is usually necessary to obtain relaxation by either

Presented before the Joint Section on Surgery and Thoracic Diseases, 104th Annual Session of the Medical Association of Georgia, May 5, 1954.



FIGURE 1

Correct method of obtaining stress film for an injury of the lateral collateral ligament. The ankle is being forcefully inverted by applying pressure on the heel.



FIGURE 2

Incorrect method for obtaining stress inversion films. Pressure is being applied on the forefoot and therefore is dissipated.

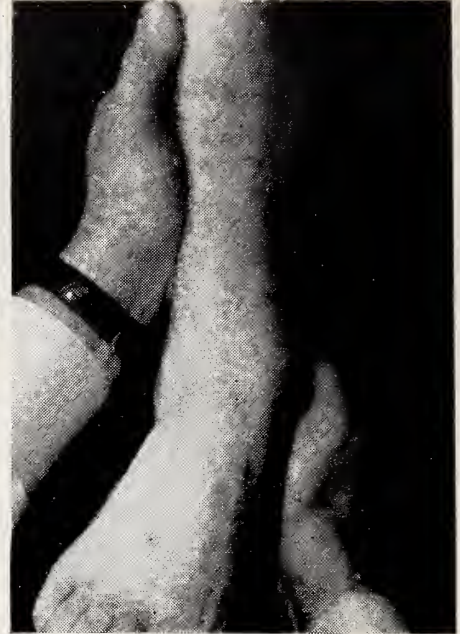


FIGURE 3

The proper method of obtaining stress film for injuries of the deltoid ligament.

injecting the trigger zone with 10 cc. of one per cent procaine, or the peroneal nerve may be injected just below the head of the fibula with two or three cc. of one per cent procaine. This will permit the examiner to forcefully manipulate the ankle into an inverted or everted position. Figure 1 demonstrates the correct way of applying the force, this being applied at the sub-taloid joint and heel. Figure 2 demonstrates the incorrect method, as in this illustration the force is being applied on the foot. Figure 3 demonstrates the proper method of applying force for a suspected injury of the deltoid ligament. If, upon inverting the ankle, the radiographs show tilting of the talus, the lateral collateral ligament has been torn, and, likewise if upon everting the ankle the talus is tilted, this is proof of a tear of the deltoid ligament. Figure 4 includes the routine radiographs of the patient who received an inversion injury of the

ankle. These were interpreted as being negative. However, an inversion stress film was made and this revealed rather marked tilting of the talus indicative of a tear of the lateral collateral ligament. (Figure 5). Collateral ligament tears should be immobilized



FIGURE 4

Normal routine radiographs of a patient who had a "sprain" of the ankle.



FIGURE 5

An Antero-posterior radiograph with marked tilting of the talus as demonstrated by applying correct stress.

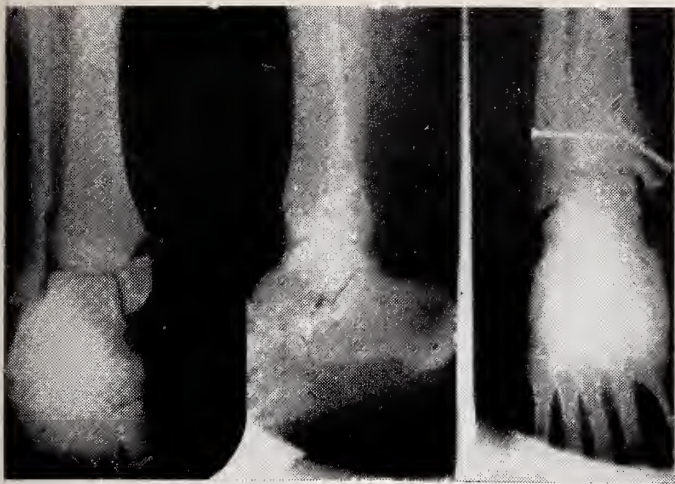


FIGURE 6

Adduction type fracture of the ankle with diastasis. The talus is shifted laterally also because of disturbance of the mortise. Correction has been accomplished by an open reduction. The mortise is no longer widened as it has been corrected by inserting a screw from lower fibula to tibia.

in a short plaster boot. The period of immobilization will vary from three to six weeks or longer. A walking heel may be added for partial weight-bearing. If the immobilization is not carried out, a chronically weak and unstable ankle will often result. A tenodesis operation using the tendon of the peroneus brevis to reconstruct the lateral collateral ligament has been very helpful in patients with these symptoms. In this procedure, the tendon of the peroneus brevis is passed through drill holes in the fibula and talus and re-sutured to itself or to the calcaneus.

Widening of the Mortise

If the interosseus ligament is torn, there is disruption of the mortise. Again, an abduction force may tear the interosseus ligament and a widening of the space between the lower end of the tibia and fibula

will be noted. The articular surface of the talus no longer fits closely between the malleoli. This, too, must be corrected or an unstable and painful ankle will result. One will note, upon examining a patient with a widened mortise or diastasis, swelling and deformity of the ankle. There is abnormal movement of the distal fibula in an antero-posterior direction. The routine antero-posterior radiographs will usually show the widened space between the lower tibia and fibula. It is best demonstrated, however, by forcefully displacing the ankle laterally as a unit. If the diastasis is minimal, one may correct it by applying a short leg cast and molding the malleoli together. If there is considerable swelling and the diastasis is of moderate or severe degree, then it should be corrected by inserting a two inch stainless steel screw across the lower fibula and into the tibia. It should then be immobilized for a period of four to six weeks in a short leg cast. The radiographs shown in Figure 6 are those of a patient who had a diastasis of the ankle associated with a fracture involving the medial malleolus. Both were corrected with screw fixations.

Fractures and/or Dislocations

An external rotation force will result in an oblique fracture of the lower fibula. This may be associated with a fracture of the medial malleolus resulting in a bimalleolar fracture. A trimalleolar fracture will be noted if the posterior process of the tibia is fractured. Figure 7 illustrates a bimalleolar fracture of the external rotation type. The talus has shifted laterally. In Figure 8, correction has been secured by an open reduction and internal fixation using a single screw to fix the medial malleolus. The talus which was displaced laterally now has been restored to its normal position and abuts against the medial malleolus.

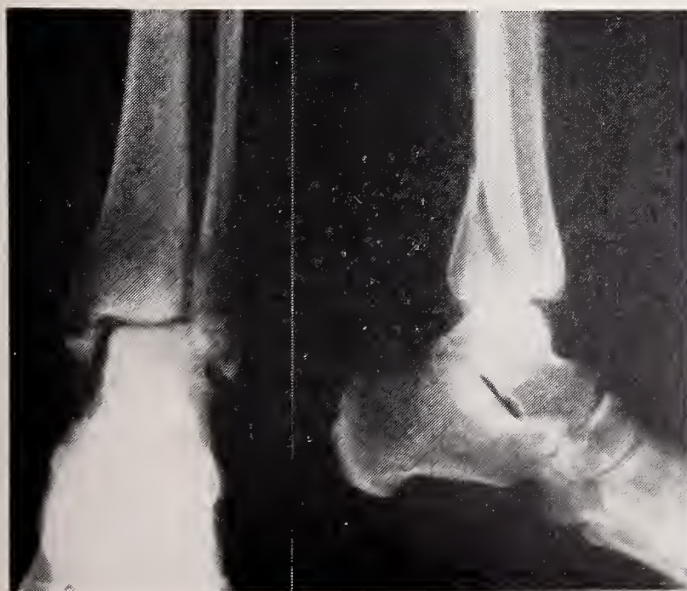


FIGURE 7

A rotation fracture of the ankle with lateral displacement of the talus. The fractures involve the medial malleolus, lower fibula, and posterior articular surface of the tibia.



FIGURE 8

Position of ankle after fixing medial malleolus with a single screw.



FIGURE 9

Severe external rotation fracture-dislocation of the ankle, the foot being displaced laterally and posteriorly.



FIGURE 10

Final end result showing complete restoration of normal joint continuity. Diastasis no longer exists.

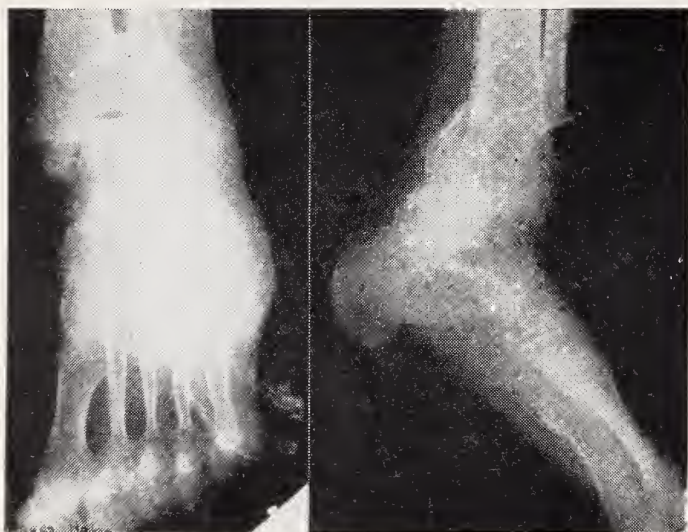


FIGURE 11

Abduction fracture of the ankle with posterior and lateral displacement of the talus. This represents a trimalleolar fracture.



FIGURE 12

Position after reduction by closed manipulation.

Figure 9 is an example of a very severe external rotation force and is a trimalleolar fracture. There is marked disruption posteriorly and laterally. The diastasis was corrected by inserting a screw from the lower fibula to the tibia and the medial malleolus was also fixed with a single screw. (Figure 10). This patient has a very good result. An abduction force will result in a transverse fracture of the fibula within two or three inches of the distal portion. Rarely, it may be associated with a fracture involving the medial malleolus. These fractures may be accompanied by lateral and posterior displacement of the foot. Figure 11 demonstrates this type fracture. This was successfully treated by closed reduction. (Figure 12).

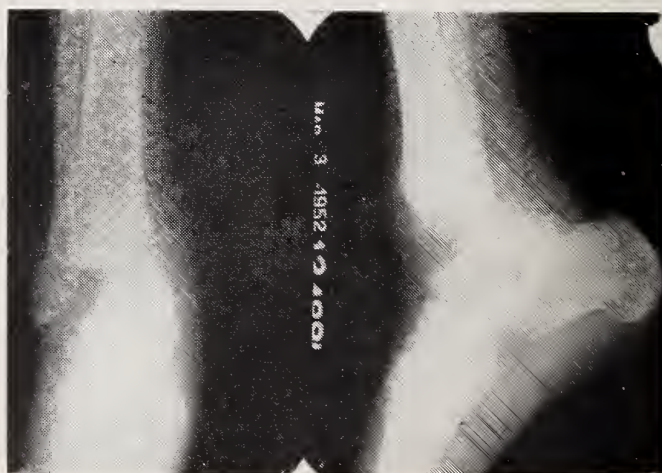


FIGURE 13

Four week-old dislocation of ankle. There is a flake fracture of the superior and lateral aspect of the talus.

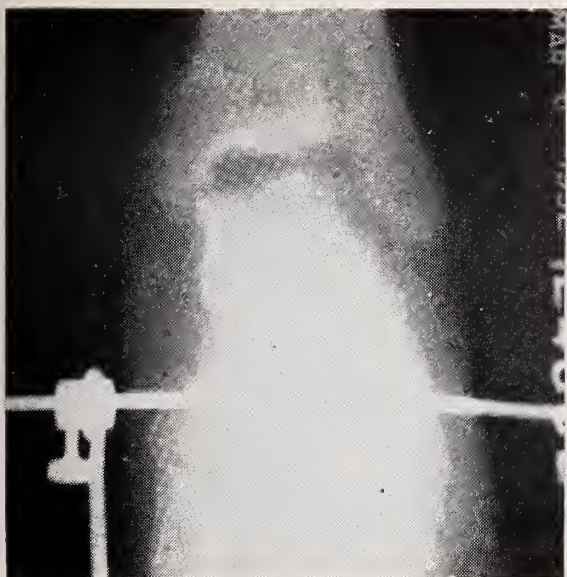


FIGURE 14

An Antero-posterior radiograph of the ankle with 40 lbs. of skeletal traction with failure to reduce the dislocation.



FIGURE 15

Radiographs at the present time following an open reduction. He has a good result at the present time but it is to be expected that secondary arthritic changes will develop later.

The adduction type fracture is the third most common. This results in a fracture of the tip of the lateral malleolus alone, or, if the force continues, there may be a fracture of the medial malleolus to include a portion of the metaphysis of the tibia. (Figure 6). A posterior marginal fracture of the tibia may also be seen, and these fractures may be associated with medial and posterior displacement of the foot. Falls from a height may result in a vertical fracture of the articular surface of the tibia. The force is transmitted through the calcaneus to the talus and to the tibia.

Figure 13 demonstrates a dislocation of the ankle in which the talus was dislocated medially and posteriorly. This patient was not seen by the authors until almost one month after his injury. There is also a fracture involving the superior and lateral surface of the talus. An attempt was made to reduce this by

closed manipulation, but this was unsuccessful. Following this, skeletal traction was applied inserting a Steinman pin through the calcaneus. (Figure 14). Again, a reduction was not effected because of the contracture of the soft tissue and ligaments. Therefore, an open reduction was done. (Figure 15).

Lateral dislocation of the sub-talar joint is quite rare. The authors have, at the present time, a patient with this injury. It is associated with a concomitant fracture of the medial malleolus and flake fractures of the calcaneus and cuboid. A closed reduction was effected by grasping the heel, displacing it forward and shifting it medially. At the same time the ankle was dorsiflexed and inverted. (Figures 16 and 17).

Fractures of the neck of the talus with sub-taloid dislocation are not common. Within the past year, we have had three patients with this injury. The radiographs will disclose that the body of the talus

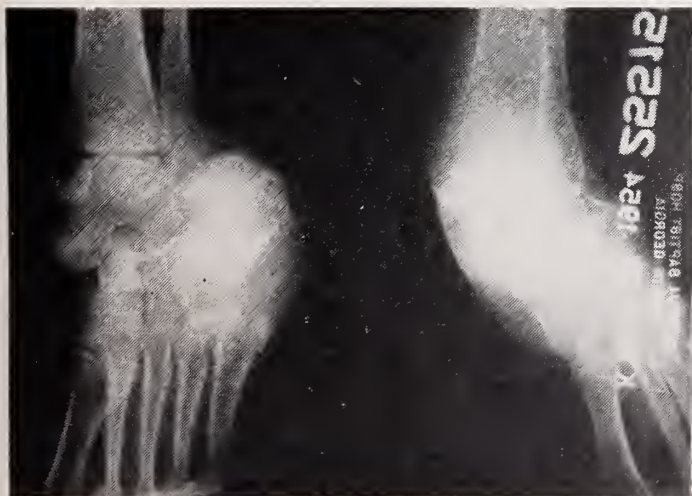


FIGURE 16

Lateral sub-talar dislocation with concomitant chip fracture of the calcaneus and cuboid and medial malleolus.



FIGURE 17

Position after closed reduction and application of plaster cast.

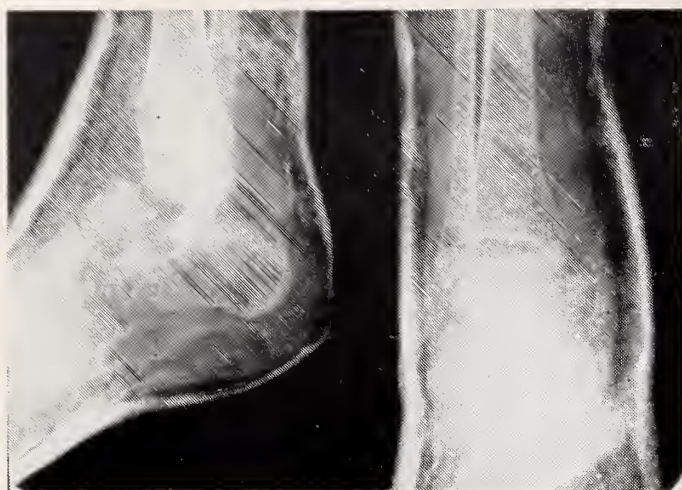


FIGURE 18

Fracture of the neck of the talus with dislocation of the posterior half of the sub-taloid joint. Note that the body of the talus is plantar-flexed with respect to the remainder of the talus and foot.



FIGURE 19

Radiographs showing reduction has been accomplished and the fracture involving the neck has healed but there is aseptic necrosis of the body of the talus.

is plantar-flexed, whereas the head and neck and remainder of the foot is displaced superiorly and medially. (Figure 18). In order to reduce this, one must plantar-flex the foot and also evert it. The foot must be maintained in extreme plantar flexion for a period of two or three weeks and then the cast should be changed and the degree of equinus reduced. If avascular necrosis results because of injury to the blood supply of the body, (Figure 19), then non-weight-bearing should be continued until revascularization has occurred.

Treatment: For fractures of the ankle without displacement simply immobilize them in plaster until healing is complete. One should attempt a closed reduction under a general or spinal anaesthetic if there is displacement. Complete relaxation is essential. The patient is placed in a supine position and the entire extremity is allowed to hang over the table at a right angle in order to relax the posterior calf muscles. The typical displacement in a bimalleolar or Pott's fracture is a posterior and lateral displacement of the ankle and foot. This fracture is reduced by displacing the foot anteriorly to correct the posterior displacement and then shifting it toward the medial side by applying two-point pressure, one point being at the lower tibia just above the medial malleolus and the other point on the lateral side of the

ankle and foot. The extremity is immobilized in a short leg cast being careful to apply sufficient padding over the pressure points medially and laterally. It is molded as the plaster sets. A slightly inverted position of the foot may be used to an advantage to maintain the reduction. However, this is not always necessary. If the post-reductive radiographs disclose a satisfactory reduction of the fracture, the patient is spared an open reduction. If the reduction is unsatisfactory, then an open reduction should be done and the medial malleolus fixed with a single stainless steel screw. The initial plaster is changed at five weeks, and a short leg walking cast applied. Weight-bearing is allowed, and this is removed at 10 weeks post-fracture, and active rehabilitation and exercises instituted. As soon as the residual soreness and stiffness have disappeared, weight-bearing is allowed.

Summary

Injuries of the ankle are common, and one who undertakes their treatment should be prepared to make a correct diagnosis and institute prompt and effective treatment in order to prevent residual pain and disability. Many of these injuries can be treated by closed methods. However, if this is not possible, an open procedure should be done.

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A.M.A. Convention Highlights

HIGHLIGHTS OF THE inauguration of Elmer Hess of Erie, Pa., as 109th president of the American Medical Association will be broadcast nationwide on Tuesday evening, June 7, during the Association's 104th Annual Meeting. The ceremonies will be held in the Ballroom of Convention Hall at Atlantic City,

New Jersey.

An added attraction will be an address by the celebrated Norman Vincent Peale, D.D., pastor of the Marble Collegiate Church of New York City. Dr. Peale will speak on "The Relationship of Religion and Medicine."

Advances in Cholecystography

RICHARD A. ELMER, M.D., and J. L. CLEMENTS, JR., M.D., Atlanta, Ga.

NEW MEDIA FOR cholecystography and popularization of newer techniques have stimulated renewed interest in roentgen examination of the gallbladder. Recent articles have discussed physiology,⁵ advantages of new media,¹ special techniques,²⁻⁶ significance of duct visualization,⁴ and correlation of radiographic and surgical findings in gallbladder disease.³

Technical factors in cholecystography are important, and varying opinions exist concerning the superiority of erect versus decubitus views in the demonstration of calculi.

Duct visualization is relatively new, and final opinions have not yet crystallized concerning reflux visualization of the common hepatic duct, caliber of the normal and abnormal common bile ducts and significance of duct visualization *per se*.

It is the intent of this presentation to discuss in a general way the gall bladder examination as it is performed in many radiographic departments, and to analyze the results.

As will be shown, the project was carried out using a reasonably standard technique, with realization in advance of several problems which we desired to study. Our particular interest concerned duct visualization and maximum efficiency in the detection of gall stones.

Material and Techniques

Three hundred fifty-six consecutive cholecystograms performed at Crawford W. Long Memorial Hospital in the six month period ending December 31, 1953, represent the basis for this study. The following routine was set up in advance:

Radiographs were obtained 12 to 16 hours after contrast media ingestion. With a small percentage of exceptions, each patient received six Telepaque tablets. The following films were obtained: (1) One or more recumbent films. (2) Upright views obtained in all patients who could stand. With the patient in 15 to 30 degree left anterior oblique position the

gallbladder is frequently visualized free of superimposed intestinal shadows. The oblique position will frequently be the difference between a satisfactory and an unsatisfactory erect view. (3) Right lateral decubitus view obtained with the patient on the table using sheet or towel rolls under the chest and hip. The grid cassette can be held by the patient or fixed in proper position by sand bags. (4) Serial recumbent films after Cholex, the first being obtained 10 to 20 minutes after fat and the second after an additional 15 minute interval. In the entire series there were 101 cholecystograms performed in conjunction with other examinations, mostly those of the upper gastro-intestinal tract, and in this group the post-cebum films were not made.

Analysis of Material

An analysis of the radiographic findings in the 356 cholecystograms is tabulated in tables I and II. Calculi were visualized in 30 patients and in six of these the diagnosis could be established only in the dependent views of the gallbladder. In the entire series, the gallbladder was visualized well with the patient in a decubitus position in 169 (70 per cent) of the examinations. Satisfactory gallbladder visualization was obtained in the erect posture in 157 (65 per cent) of the examinations.

In 31 cholecystograms (13 per cent) there was unsatisfactory visualization of the gallbladder in both the erect and the decubitus views due to obscuring intestinal shadows, but in these examinations a combination of both of these views was often helpful. Spot film radiographs with varying degrees of obliquity and compression have been an aid in visualization of gallbladders without interfering shadows, and this is recommended as a procedure to be used when the erect and decubitus views fail to outline the gallbladder adequately. This type of erect film examination may be used routinely if desired. Because of the relatively high incidence of stones which are not visualized in routine recumbent films, a gallbladder examination should include at least one good view of the gallbladder in the erect or the decubitus posture. In these views calculi may layer at any level within the gallbladder, but are most frequently seen in the most dependent portion of the gallbladder. It

The authors thank James F. Olley, M.D., for reviewing all of the pathologic slides on removed gallbladders in this group of patients.

Presented before the Section on Radiology, 104th Annual Session of the Medical Association of Georgia, May 3, 1954.

is our impression that in general the erect view in the left anterior oblique position is more satisfactory in patients with an athletic or pyknic body-build, whereas the decubitus view has been more satisfactory in the asthenic type patient. One or both of these views can be obtained in any ordinary department of radiology, though an upright or portable bucky is a definite aid in the erect views.

TABLE I ANALYSIS OF RADIOGRAPHIC FINDINGS		
Cholecystograms—Including post-fat films	255	
Cholecystograms—Without post-fat films	101	
Total	356	
Normally functioning gallbladder without evidence of cholelithiasis	240	65.6%
Gallbladder visualized with cholelithiasis	25	6.8%
Non-visualized or poorly visualized gallbladder without opaque calculi	85	23.2%
Non-visualized gallbladder with opaque calculi	5	1.4%
Unusual abnormalities	4	1.1%
Calculi visualized	30	8.2%
Calculi diagnosed only in the dependent view	6	20.0%

TABLE II DECUBITUS VS. ERECT VIEWS		
Gallbladder visualized	240	
Gallbladder visualized better decubitus	77	
Gallbladder visualized better erect	65	
Gallbladder visualized equally well erect or decubitus	92	
Gallbladder poorly visualized erect or decubitus	31	13%
Good decubitus view	169	70%
Good erect view	157	65%

Of 187 cholecystograms showing good dye concentration, visualization of the common bile duct occurred in 78 (41 per cent). (Table II). The common bile duct was frequently visualized in more than one of the post-fat films, but it was most consistently demonstrated in the film obtained 10 to 20 minutes after the fat meal. Six-four (82 per cent) were better visualized at this time.

The visualized common bile ducts were arbitrarily grouped according to caliber. Ducts of no more than four mm. maximum diameter were considered small; ducts of maximum diameter between five and eight mm. were considered medium, and ducts of maximum diameter of nine mm. or more, considered large. Table III shows the breakdown of the common bile ducts according to caliber.

TABLE III DUCT VISUALIZATION (In 187 visualized gallbladders)		
Duct visualization	78 (42%)	
Small (maximum diameter 4 mm. or less)	30	
Reflux into common hepatic duct	5	
Medium (maximum diameter 5-8 mm.)	40	
Reflux into common hepatic duct	11	
Large (maximum diameter 9 mm. or more)	8	
Reflux into common hepatic duct	4	
Total reflux into common hepatic duct	20	
Better duct visualization 10-20 min.	64	
Better duct visualization 20-30 min.	14	

In 20 cholecystograms there was definite reflux of contrast media into the common hepatic bile duct (about 27 per cent of cholecystograms with common bile duct visualization), and reflux occurred in one in six patients with small caliber common bile ducts. There was, however, an increase in the incidence of the reflux into the common hepatic duct with an increase of the caliber of the common bile duct.

Sachs⁴ has stated that reflux into the common hepatic duct was not possible without distal obstruction, usually at the sphincter of Oddi. Our experience, using Telepaque and without drugs to influence the sphincter of Oddi, indicates that reflux common of pathologic change.

What constitutes a normal caliber common bile hepatic duct visualization is quite common and is in itself no indication of altered physiologic function or duct is difficult to answer. There is a wide variation in the size of the common bile duct from patient to patient, and the diameter of the common bile duct in the same patient is quite variable. Incomplete filling of the duct by a small amount of the contrast media may give a false impression of the actual size of the lumen of the duct. If the lumen of the common bile duct measures 7.5 mm. anatomically, then a fully distended common duct might be expected to measure as much as nine to 10 mm. when taking into account the magnification in the routine radiographic exposures.

In one of our patients the common bile duct was well outlined and measured up to 11 or 12 mm. in maximum diameter. Serial films up to 45 minutes after the fat meal demonstrated some contrast media retained within the duct. This patient had a chronic duodenal ulcer. Three months after sub-total gastrectomy the examination was repeated, and again the common duct was well outlined, showing the same size as before. The patient had become asymptomatic following convalescence and has remained well. There is no doubt that the common bile duct seen in this patient is unusually large; however, there was no fibrosis or other abnormality observed in the region of the sphincter of Oddi at the time of gastrectomy, and the absence of symptoms would tend to indicate that in this patient the duct of 11 to 12 mm. is not pathognomonic of disease. Another indication of what might be considered as a radiographic normal is a cholangiogram done in a patient whose gallbladder and common bile duct were visualized at the time of surgery and were grossly normal. A small caliber catheter was placed into the common bile duct to localize the common bile duct and the sphincter of Oddi to avoid damage during surgery. Cholangiograms on this patient show the common bile duct to measure 10 to 11 mm. in maximum diameter. The common bile duct was seen to fill

readily at fluoroscopic observation; there was no evidence of pressure distention of the common bile duct.

Because of the limited number of patients who have had thorough surgical exploration after visualization of a common duct measuring seven mm. or more in diameter by cholecystography, we must conclude that a positive statement concerning the upper limits of normal duct caliber cannot be made. Suffice it to say that many patients will demonstrate ducts of seven to 12 mm. in maximum diameter and that duct size *per se* is of limited importance.

Analysis of 33 patients who underwent cholecystectomy can be found in table IV in which the radiographic findings are correlated with the histologic diagnosis upon the excised gallbladder. Of major interest to us were two findings:

1. Of 33 patients who had cholecystectomy, 19 had a gallbladder of "normal" density. In 14 of these 19 patients there was definite evidence of subacute and chronic cholecystitis. Some of these showed varying degrees of acute cholecystitis.

2. Of 20 patients who had stones in the gallbladder, there were six in whom there was no evidence of cholecystitis. Some of these showed edema without cellular infiltration. Gallbladders exhibiting Rokitsky sinuses without other alterations were classified as normal. Fourteen of the 20 patients with biliary calculi had chronic cholelithiasis. There was one patient in whom a calculus was found in the cystic duct. In this patient the gallbladder was visualized on two occasions, but no stone was demonstrated.

TABLE IV
COMPARISON OF RADIOGRAPHIC AND HISTOLOGIC FINDINGS

Radiographic Diagnosis		Histologic Diagnosis	
Non-function— No opaque calculi	11	Calculi	8
		Cholecystitis	6
		No cholecystitis	2
		Normal—No calculi	2
Normal function— No calculi	6	Cholecystitis—No calculi	1
		Cholecystitis	5
		Stone in cystic duct	1
		Cholecystitis—No calculi	1
Normal function— calculi	12	Calculi	12
		Cholecystitis	8
		No cholecystitis	4
Non-function— opaque calculi	3	Calculi	3
Normal function— Papilloma	1	Cholecystitis	3
		Papilloma	1
		Cholecystitis	1

Anomalous forms of the gallbladder which under certain conditions can simulate opaque calculi and layering of the contrast media in the upright and decubitus views, which may simulate non-opaque calculi and represent variations of the normal gallbladder. There should be no real problem of differential diagnosis when viewing an entire series of radiographs.

Of special interest in our series were four patients

with unusual findings. One with a papilloma measuring 2 x 2 x 3 mm. was unusually well visualized despite a very dense gallbladder shadow. This was proved histologically. Another patient demonstrated what appears to be gas within the gall bladder and definite gas in the biliary tree. Gastrointestinal series done at a later date demonstrated a fistulous communication between the duodenum and the biliary tree. A third patient with a non-functioning gallbladder demonstrated a fluid shadow of calcific density in the right renal area. Layering of this density was demonstrated in the erect views. The exact nature of this density has not been proved. In a fourth a cystic calcification was demonstrated in the liver. This patient also had a non-functioning gallbladder.

The Future of Cholecystography

In the past several years strides have been made in cholecystography by the popularization of the erect and decubitus views and by the introduction of new and improved cholecystographic media. In recent months there has been used in Europe, and to some extent in this country, an intravenous contrast medium which will allow visualization of the extrahepatic biliary tree from 10 minutes to two hours after injection. Weens and Meadors⁷ have examined 14 patients by this method and have visualized the common duct in 13 of these patients. This method is particularly applicable in examining patients who have had cholecystectomy, and will be helpful in some instances when a wait of eight to 20 hours for oral cholecystography is not desirable.

Further improved contrast media can be expected to appear and should prove of value in better accuracy of radiological diagnosis in cholecystography. With increasing frequency of visualization of the biliary ducts, there will be in time a better understanding of the normal duct, its variations and its significance.

Summary

1. Three hundred fifty-six consecutive cholecystograms have been analyzed. A fairly uniform technique was employed, including films in erect and decubitus positions and serial post-fat films.

2. Upright and decubitus films were almost equally satisfactory in obtaining good visualization of the gallbladder free of obscuring shadows. At least one good view of this type should be included in all cholecystograms.

3. Visualization of the common bile duct occurred in 42 per cent of the patients who received a fat meal. A majority of the ducts showed a diameter of below nine mm. Reflux of the contrast media into the common hepatic duct was a common finding and in itself considered to be of no significance.

4. Cholecystitis was diagnosed histologically in 14 patients showing a gallbladder of normal density on cholecystography.

5. In 20 patients with cholelithiasis there were six patients in whom the gallbladder failed to show histologic evidence of cholecystitis.

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Memorial to John F. Denton

THERE COMES A SHOCKING pause when some one like John F. Denton, one of Atlanta's most respected physicians, dies. He was a native of Dalton, Georgia, born there September 22, 1877, the son of John F. Denton. He obtained early education at Webb's School, graduating in 1896, and at Emory-at-Oxford (where he was a schoolmate of Senator Barkley), with an A.B. degree. His doctorate in medicine was earned at the New York University Medical School, 1903. After postgraduate work at Bellevue Hospital and the New York City Health Department, he returned to Atlanta to practice in 1906.

He held the Chair, Professor of Clinical Gynecology at Emory, for years, and was visiting gynecologist to Grady Memorial Hospital, Steiner Cancer Clinic and Emory University Hospital. During World War I, with the rank of major he was stationed at Fort McPherson. Dr. Russell Burke, a devoted friend, now has Doctor Denton's "gold leaves" which designated his Army rank. He was a member of the Board of Trustees of the American Cancer Society, Georgia Division, and of the Judicial Council of the Fulton County Medical Society, of which he was a Life member.

Sigma Alpha Epsilon and Phi Alpha Sigma were the fraternities to which he belonged; other organizations of importance were the American Medical Association, Medical Association of Georgia, Southwestern Obstetrical and Gynecological Society, the staffs of several local hospitals; and the First Presbyterian Church, which he faithfully attended.

Dr. Denton is survived by his devoted wife, Mrs. Maude Johnson Denton; a daughter, Mrs. J. P. Garlington; his brother and sister, Mr. William and Miss Elizabeth Denton of Dalton; two grandchildren, Lieutenant Peek Garlington and Mrs. James W. Reilly.

In the many years of a long and active practice, Dr. Denton, together with teaching in the medical

school and clinics, contributed much to his specialty, and he was considered the dean of Atlanta Obstetricians. From a professional viewpoint his contributions were not necessarily those of the researcher, but those of the clinician and therapist. He was a plugging worker who adhered strictly to the highest traditions of his field, who worked best when he believed that his procedures were based on sound, practical principles. I know that he never felt that he was a better doctor than his confreres, but he aspired to be as good as the best in his group.

Dr. Denton, with his good wife and other members of his family not too far away, lived an active, happy and tranquil life. However, as all mortals do, he had troubles. The death of one of his brothers in Dalton, following an unfortunate accident, distressed him severely. In the last few months, we who so often met with him for our daily talks, realized that he was also ailing. We noticed how slowly but surely the deepening shadows were crossing his pathway, observed his loss of weight, noted the short breathing and saw the effort of walking as he attempted to accommodate himself to the physical demands of his body. He knew what these difficulties signified and finally decided to close up shop.

If I can summarize that good man, I should say that Dr. Denton was a moderate man in all things, a well born, distinguished person, calm and unexcitable in his work, a man with a vast practical experience in many things. He lived as he believed one ought to live. He gave the best of himself to his patients and was loyal to his friends. He had a high sense of honor. Neither grandiose things nor money attracted him, and he always did his conscientious best in fulfilling his responsibilities. For him there was no other way; he has left a magnificent example of fidelity and professional integrity which it well behooves us all to follow.

Jack C. Norris

Current Status of Antimicrobial Agents In Pediatrics

BENJAMIN M. KAGAN, M.D., Chicago, Ill.

TWENTY YEARS AGO it was of the utmost importance to know whether a patient had meningitis or pneumonia because the choice of therapy of choice in infections depends more upon the important to know the causative organism—that is whether it is an influenza bacillus or a pneumococcus which is responsible for the illness. Today, the therapy of choice in infections depends more upon the etiology than upon the area of the body affected. It is still important to know the site of the clinical infection, but principally because it gives us a lead as to the most probable etiology.

The difference between antimicrobial therapy in pediatric practice and that in internal medicine is related to the marked differences in the etiology of the various clinical entities in infants and children as compared to adults. A good example is meningitis. In the premature infant and the newborn, meningitis is most often caused by *E. coli*. For meningitis in this age group, therefore, at least until the bacteriologist reports on the culture, chloramphenicol or tetracycline would be the drug of choice. Between the ages of one and three years, meningitis is more likely to be due to the influenza bacillus, and chloramphenicol again appears to be the initial drug of choice. On the other hand, over three years of age, meningitis is most often caused by the meningococcus—in which case sulfonamide, with or without penicillin, would be the initial therapy.

Thus, knowledge of the most likely causative organism is an essential step in the initial choice of the most effective drug. Here is another example: septicemia with jaundice in an infant is most often caused by *E. coli* or a staphylococcus, whereas septicemia in infants without jaundice is most often caused by streptococci or pneumococci. It follows then that in infants with sepsis and jaundice, chloramphenicol would be the initial drug of choice; in sepsis without jaundice in infancy, the streptococcus

or the pneumococcus would be the most likely invader, and penicillin the drug of choice.

Thus the approach to antibiotic therapy in infants and children is significantly different from that in the adult primarily because of the known differences in etiology of the various clinical infections in different age groups. The clinician must make a presumptive etiologic diagnosis based upon probability and begin therapy with the most promising drug.

The culture, ideally taken before any drug is started, may be the second determining step in the decision as to whether this drug should be continued, but the culture is generally secondary in importance to the clinical response. The clinical response can often have been estimated by the time the results of the culture are available. If the response is favorable, the drug may be continued even though the laboratory report on sensitivity indicates that the drug used was among the least effective or was even without *in vitro* effect. In such cases, one should be guided by the clinical response and not the laboratory report. (In some of these cases, of course, the patient would have gotten well without any drug.)

In infections which have not yet responded, testing for *in vitro* sensitivity is another step to further pinpoint the drug of choice. The *in vitro* tests are not in themselves always the best guides to the most effective drug, and in the final analysis therapeutic trial is the most reliable. Nevertheless identification of the infecting organism and determination of its sensitivity to antibacterial agents are most worthwhile and should be done whenever there is a question as to outcome, because when the patient has not responded to the initial therapy the information thus obtained may prove helpful in choosing more effective therapy. In protracted or serious infections, the usefulness of a combination of drugs which a patient is receiving may be estimated by testing the antibacterial effect of the patient's serum against the specific infecting organism.

For the initial treatment of infection, the clinician needs to have at his fingertips knowledge of the therapy of first, second and perhaps third choice. The

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Presented before the Georgia State Pediatric Society Annual Meeting held October 28, 1954 in Atlanta, Georgia.

therapy of first choice would always be used initially except for extenuating circumstances such as sensitivity of the patient to the drug of choice. Beyond this, knowledge of other possible agents is useful as a guide in determining what *in vitro* sensitivity tests should be done.

The broad spectrum antibiotics, the tetracycline group and chloramphenicol have a range which is very similar one to the other. The tetracycline group includes chlortetracycline (commercially known as Aureomycin®), oxytetracycline (commercially known as Terramycin®) and the more recently developed tetracycline itself (commercially known as Achromycin®, Tetracyclin®, Panmycin®, Polycycline® or Steclyn®).

Among the tetracyclines, if other factors weighed equally, tetracycline itself would consistently be the drug of choice because of its stability, greater rapidity of tissue diffusion, acceptability, relative freedom from reactions, including gastrointestinal, hematologic, etc., and multiple choice as to routes of administration.

In general *in vitro* tests with one of the tetracycline drugs give the same results as with the others. However, *in vitro* studies recently reported by Welch and his group have demonstrated some differences between the tetracycline drugs against staphylococci and some strains of streptococci. It appears therefore that it would be unwise in our present state of knowledge to discard the others entirely in favor of tetracycline itself.

The tetracyclines are the drugs of choice in infections due to *Shigella*, *Rickettsia* and *Psitticosis*, and they have a wide range of usefulness against many of the other gram negative as well as many of the gram positive organisms. In some *Shigella* infections and particularly in the carrier state, oral polymyxin B may be more effective.

There are some exceptions to the overlapping range of usefulness of the tetracyclines and chloramphenicol—notably in typhoid fever and influenza meningitis, where chloramphenicol appears to be the drug of choice. Then there are the infections where other agents are definitely preferred, such as in meningococcus infections, where sulfonamide and penicillin have the advantage; in beta-hemolytic streptococcal infections, where penicillin is superior; in streptococcus *viridans* infections, where a combination of penicillin and streptomycin has proved most effective; and in tuberculosis, where streptomycin, dihydrostreptomycin, isoniazid and para-aminosalicylic acid are most valuable.

Staphylococci have shown amazing ability to adapt to each of the new agents as they have been developed. Thus they have gradually developed resistance,

or more correctly resistant strains have developed which grow in the presence of the sulfonamides, penicillin and the tetracycline drugs. In the relatively short time since erythromycin has been available, 30 per cent of the isolated strains have become resistant. Erythromycin is still the preferred single drug in staphylococcus infections. Some strains are sensitive to chloramphenicol. We have found that a mixture of penicillin and bacitracin has seemed to be life-saving in some cases. Some have found useful a combination of bacitracin intramuscularly and erythromycin intravenously. It is of interest that some strains are very sensitive to neomycin. Some staphylococcal infections of the urinary tract have responded to nitrofurantoin which is commercially available as Furadantin®.

Erythromycin does not have the broad spectrum effectiveness of the tetracycline drugs or of chloramphenicol. It is known commercially as Ilotycin® and Erythrocin®. In oral suspension the former is the ethyl carbonate and the latter the stearate form. Their rate of absorption, duration of tissue concentration, etc., are not identical. Erythromycin is particularly useful in infections due to the gram positive organisms; staphylococci, pneumococci, beta hemolytic streptococci and somewhat less so against the enterococci and streptococcus *viridans*. I prefer not to use it as a prophylactic drug because of the possibility of developing infection with a strain of staphylococci resistant to it and because of its relatively weak effect against gram negative organisms. A resistant strain of staphylococci can develop within five or six days of exposure. In some instances it has been used synergistically with other antibiotics such as tetracycline, and with bacitracin.

For pseudomonas or pyocyanous infections polymyxin B is the drug of choice. The high degree of renal toxicity originally reported with polymyxin D has fortunately not been observed with therapeutic doses of polymyxin B. Polymyxin D is no longer available. In the absence of serious renal damage, polymyxin B may be used with relative safety by the intramuscular route. It is particularly useful in meningitis, septicemia, urinary, gastro-intestinal and other infections due to pseudomonas.

During the past few years we have come to appreciate far more than previously the importance of pseudomonas in gastrointestinal infections. At times it appears to be responsible only for distention and ileus in small infants. Frequently it has been the only detectable possible pathogen in cases of persistent or severe diarrhea. Formerly, we were inclined to think that pseudomonas was merely a secondary invader in the intestinal tract. It is probable that it is often present only in the carrier state. However,

since we have had experience with polymyxin in eradicating it, we are more impressed with its power to be pathogenic.

Before the availability of polymyxin B, Shaffer and Oppenheimer reported similar observations of the pathogenicity of pseudomonas. They pointed out that treatment with penicillin appears to stimulate the growth of pseudomonas by killing off antagonistic organisms. Of particular interest are five infants who died of ulcerated appendices, several of which had perforated. The microscopic picture in all was similar. The tissues appear to have been killed without evocation of an inflammatory or polymorphonuclear response in the tissues. Deep in the necrotic tissue there were swarms of gram negative bacilli. In all of these cases pseudomonas had been demonstrated in the stool, blood or spinal fluid.

When the pseudomonas is limited to the gastro-intestinal tract, oral polymyxin B is effective. It is not appreciably absorbed by this route, and there is little or no untoward reaction. Often within 24 to 48 hours the clinical condition is much improved. Within four to seven days the organism is often eliminated from the gastro-intestinal tract. Relapse is less likely if the drug is given for at least seven to ten days.

Polymyxin B should be administered early in the event of any outbreak of diarrhea of the newborn due to pseudomonas. It is quite effective also in eradicating the organism from asymptomatic carriers.

For systemic infections due to pseudomonas such as meningitis, septicemia, urinary tract infections, etc., it must be given parenterally.

Intramuscular injection of this drug is associated with a moderate amount of local pain in a number of cases. This is alleviated when it is injected with procaine. In about a third of the children, we have noted moderate to marked degrees of lethargy, irritability and anorexia beginning about the second or third day of intramuscular therapy. These symptoms almost always improve in spite of continuation of therapy and clear completely soon after the drug is stopped. The most serious evidence of toxicity we observed has been ataxia. This cleared within 24 hours after the drug was stopped.

A few children develop urticaria or flushing of the face. Adults often complain of a feeling of having had a "close shave." They also develop paresthesias of the hands and feet. These are alleviated considerably by antihistaminic drugs. In the past year we have routinely given an antihistaminic drug whenever parenteral polymyxin B was started.

Oral neomycin, chloramphenicol and polymyxin B are the most effective drugs for the treatment of the recently described cases of diarrhea of the newborn

due to specific strains of *E. coli*, e.g., *E. coli* 0111, 055, 0126 and 0127. In such an outbreak one would ordinarily start neomycin by mouth promptly. Here, however, is a good example of the need for *in vitro* tests; for some strains are completely resistant to neomycin and sensitive only to chloramphenicol.

Aerobacter aerogenes most often causes urinary tract infection, but it has also been responsible for septicemia, meningitis, respiratory infection and perhaps some gastro-intestinal infections especially of the biliary tract. Available drugs leave much to be desired but chloramphenicol or polymyxin B seem to be most effective. In some, the tetracycline drugs, streptomycin or a combination of streptomycin with tetracycline has been effective.

In systemic proteus infections, no drugs have been outstanding. A few patients have survived serious proteus infections after the use of combinations of penicillin and chloramphenicol, and some have responded to streptomycin or neomycin. In the urinary tract, Furadantin may result in sterile urine if renal function is good and particularly if any important causes for urinary stasis can be relieved.

In *Salmonella* infections other than typhosa, clinical improvement can be obtained, but the carrier state has been very difficult to eradicate. Preliminary *in vitro* studies in our department suggest that a combination of polymyxin B with tetracycline or with chloramphenicol may be helpful. None of these drugs alone has been entirely satisfactory although oxytetracycline has been more effective than the others in more of the reported cases.

Actinomycosis is the only systemic mycotic infection which responds favorably to an antibiotic. Here massive doses of penicillin should be given at first followed by smaller doses for at least one month after apparent cure.





In generalized moniliasis we are still without effective therapy. Moniliasis limited to the intestinal tract results mostly following prolonged antibiotic therapy. It may cause troublesome diarrhea occasionally with ulceration, local rectal irritation and anal fissure. In such intestinal infection, a new antibiotic, fungicidin or nystatin, has been helpful. It is commercially available as Mycostatin®. It is effective against most fungi and yeast, except actinomyces. Within 24 to 48 hours after oral administration, a clinically favorable effect may be observed. Since it is very poorly absorbed and is too toxic for parenteral use, it is not effective for monilia infection outside the intestinal tract.

In animal experiments, some antibiotics in combination are antagonistic to each other. The experience with humans is more limited and based mainly upon observations by Dowling, Lepper and

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co-workers, who found the combination of penicillin and chlortetracycline to be less effective in pneumococcal meningitis than either one alone.

In most instances the use of combined antibiotic therapy is not supported by available laboratory or clinical evidence. The best procedure appears to be to use the drug of first choice, based upon such reasoning as already outlined, and thereby minimize the risk of untoward reaction, increase the therapeutic reserve, lessen the possibility of reducing the effectiveness of the drug of choice or subsequently used drugs and reduce the possibility of errors in administration, particularly as to dose, routes and time intervals. On the other hand, particularly in infections of the respiratory tract such as acute laryngotracheobronchitis which is most often due to either the hemolytic streptococci or *H. influenzae*, use of a combination of two bactericidal drugs such as penicillin and streptomycin is based on sound reasons and is effective. Likewise in such infections as bacterial endocarditis, similar combinations may be life saving. Except in tuberculosis, it is very rare that a combination of more than two antimicrobial agents is indicated.

The use of antibiotics together may be additive and in some cases actually synergistic. Good examples of synergism are demonstrable with penicillin and streptomycin or penicillin and bacitracin. The primarily bacteriocidal drugs also have a bacteriostatic effect, but their bacteriocidal effect may be lost if used in combination with primarily bacteriostatic drugs. On the basis of the available information it appears that if one finds a combination necessary, one should avoid using a primarily bacteriocidal drug with a primarily bacteriostatic one unless it is only the bacteriostatic effect which is desired. When used for the bacteriostatic activity, such combinations are generally additive rather than synergistic. The primarily bacteriocidal drugs are penicillin, streptomycin, dihydrostreptomycin, polymyxin B, bacitracin and neomycin. Their use together may be synergistic. Erythromycin appears to have both a bacteriocidal and a bacteriostatic effect. The primarily bacteriostatic drugs are the sulfonamides, the tetracyclines and chloramphenicol.

An important factor in the choice of any drug for children is ease of administration. This, in turn, may depend upon whether the child can or will accept it orally. Oral medication is generally preferred because it may be less traumatic for the child and may be easier for the personnel concerned, but mostly because the incidence and severity of untoward reactions is less. The danger of anaphylactoid reaction to parenteral penicillin is now sufficiently great to warrant its administration by the oral route when-

ever possible. The taste of the preparation and the frequency with which it has to be administered are necessary considerations. A number of acceptable vehicles for penicillin are available for oral use. The new amphoteric forms of chloramphenicol and the tetracycline drugs have made them much easier to administer to children. On the other hand, in infants under six months of age, their absorption appears to be less dependable than that of the crystalline forms. The absorption of these forms, particularly in young infants and in patients with difficulty in digestion of fat, needs further study.

Most of the antibiotics are available for intramuscular or intravenous injection. We have successfully used oxytetracycline, or Terramycin®, subcutaneously in premature and full term infants and in infants weighing less than 20 pounds. It is well tolerated, and the injections need be given only every 12 hours. Aqueous suspension of procaine penicillin given every 24 hours has largely replaced crystalline penicillin for intramuscular use. When higher tissue concentrations are desired, it is well to give it every 12 hours. When lower tissue concentrations are adequate and desired for longer periods of time, as in the treatment of or prophylaxis of beta hemolytic streptococcal infections, intramuscular benzathine penicillin is quite satisfactory. Benzathine penicillin is known commercially as Bicillin® or Permapen®. Large doses of 1,200,000 units will provide blood concentrations for three to four weeks which are adequate for prophylaxis in rheumatic fever.

The proper dose for the correct length of time is of course our goal. The tetracycline drugs tend to accumulate if the dose is only a little higher than that recommended. The toxicity of intramuscular polymyxin B is very closely related to the larger doses. It can be minimized, for example, by using a smaller dose more frequently. Freedom from toxicity due to doses of penicillin far in excess of that needed for therapeutic effect is remarkable. It may be due perhaps to the fact that penicillin does not readily pass the cell membrane of human cells whereas it readily enters bacterial cells. This should not lead us to give ever increasing doses, since Eagle's work suggests that for some bacteria there is a range of concentration for optimum bacteriocidal activity above and below which penicillin is not as effective.

In general, reactions are less common in children than in adults. Much of the human sensitivity to antibiotics is unnecessary. It can be reduced by not giving them in minor ailments, by avoiding local application of systemically useful ones, avoiding depot types unless needed, giving preference to the oral route and by avoiding simultaneous injection of other possible antigens. Probably the first is the

most important, i.e., avoid giving them when they are not necessary. Most of the antibiotics used are wasted. Between 30 and 50 tons of penicillin are being sold in this country each year. It is estimated that one out of every four people received penicillin last year—that 90 per cent is wasted.

Work in our department has shown that the most dangerous type of penicillin reaction, i.e., anaphylaxis, may be anticipated if an immediate whealing reaction occurs on cutaneous or intracutaneous testing. Delayed intracutaneous reactions, i.e., of 24 to 48 hours, may presage a delayed reaction such as a serum type of illness or urticaria. These tests are not always reliable. They should be done particularly in patients with an allergic background. If parenteral administration is necessary in such patients, it is wise to inject the drug in the arm at a low enough level so that a tourniquet may be applied if a severe reaction ensues. Preparation to meet such emergencies is now incumbent upon the physician. These preparations should include the availability of a tourniquet, sterile syringes, epinephrine, benadryl or pyribenzamine for parenteral use, and if possible oxygen. The epinephrine and antihistaminic should be given intravenously. The airway should be kept open and oxygen administered. The immediate measures may helpfully be followed by intravenous hydrocortisone or ACTH, or intramuscular or oral cortisone.

Work in our laboratory shows that some of the "anaphylactic reactions" could be due to accidental intravenous injection of aqueous suspension of procaine penicillin.

The delayed type of reactions is less alarming and responds more readily to discontinuance of the medication, ephedrine, antihistamines, ACTH or cortisone.

Prolonged administration especially of large doses of streptomycin may result in loss of vestibular function. Similar administration of dihydrostreptomycin may result in loss of hearing. The hearing loss is generally irreversible. It has been suggested that use of the two combined in one-half the dose of each will reduce the toxicity.

Chloramphenicol has a depressant effect on bone marrow, but in relatively few cases is the direct association clear cut. When detected early by blood studies, the effect is generally reversible. It should not deter us from using this drug when it is clearly superior to others—especially in conditions in which morbidity and mortality are significantly reduced by its use as compared with other drugs. This is a matter of relative balance between danger and advantage. A strong case could be made even against the common aspirin tablet if only those cases in which severe

reactions have occurred were presented as the one aspect of its character.

A recently recognized complication of antibiotic therapy is severe gastroenteritis' sometimes resembling ulcerative colitis. It is due to either staphylococcus aureus or streptococcus fecalis. It is important that the physician indicate to the laboratory that he is searching for these organisms so that suitable cultures can be made. They are not ordinarily found if the customary media for stool cultures are used. These infections may be fatal if not recognized early. Some have responded well especially with the use of erythromycin. Should it fail, oral neomycin and bacitracin should be considered.

During prolonged use of some of the antibiotics, fungus infections may become a real problem. There is some evidence that growth of fungi may actually be stimulated by some of the antibiotics of fungus origin. Most of the growth, however, is due to suppression of flora which normally inhibit the fungi. In cystic fibrosis of the pancreas or familial eccrinosis, where one of the tetracycline drugs may be given for long periods of time, even mycotic endocarditis has developed. We now have a few years experience with a method for prophylaxis which has thus far been free from this complication. In using the available antibacterial agents prophylactically, we are thinking mostly of the pneumococci and streptococci. In general, *in vitro* tests show the antibiotics to be effective in suppressing growth of these organisms when they are exposed to a sufficient concentration for even brief periods of time, e.g., less than 30 minutes in the case of beta hemolytic streptococci and penicillin. We have theorized, therefore, that if the drug is available sufficient amount with 12 to 24 hours after the onset of such infection we need not provide continuous tissue concentrations for such prophylaxis. In providing intermittent rather than continuous medication we lessen the effect upon the normal flora and therefore the danger of overgrowth of fungi and other nonsusceptible organisms. We have, therefore, used these drugs for prophylaxis in full single oral doses, given however only once every 24 or at most every 12 hours. In four years experience with this approach in our clinic population with rheumatic fever, nephrotic syndrome and fibrocystic disease of the pancreas, we have had no complications with fungus infection.

The study of antimicrobial agents is one in which the student must be prepared for change. It is a field of very active research. Moreover, change is a biological characteristic of both the organism attacked and the human host. At a recent five day session on antibiotics in Washington, 172 papers were presented. Among the more exciting newer news is the possibility of developing an antibiotic with anti-cancerous

effect and a new antibiotic, Anisomycin (Flagecidin) effective against such protozoa as trichomonas vaginalis and endamoeba histolytica. More than nine other new antibiotics were described in addition to the literally thousands which have already been reported—most of which are also too anti-human.

In brief summary, there are now 11 clinically proven antibiotics in addition to the sulfonamides and nitrofurantoin. In this necessarily quick survey we have touched upon the basis for choice among them, their toxicity and the currently accepted rationale for use in combination.

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Memorial to Thomas F. Harper

IN THE DEATH OF Dr. Thomas Fletcher Harper, which occurred at his home in Coleman, Georgia, early Saturday morning, November 27th, Randolph County lost one of its most useful citizens.

He was the son of the late J. J. Harper, formerly of Greene County, N. C., a Captain in the Confederate Army, and Mrs. Georgia Jackson Harper, formerly of Warm Springs. He was a steward and a trustee of Coleman Methodist Church, a member of the County, District and State Medical Associations, and also a member of the American Medical Association.

He graduated in 1905 from the Atlanta College of Physicians and Surgeons, which later became the medical school of Emory University. Following five years of practice at Weston, Georgia, he moved to Coleman, where he spent the remainder of his life.

Having been associated with Dr. Harper from boyhood, I came to know his true worth and to appreciate his efforts and achievements. He saw life as a field for endeavor toward the welfare and happiness of humanity, and with conscientious devotion to duty, I dare say that he spent more time in professional service than any other doctor in the State. Regardless of weather conditions, bad roads, dis-

tance or late hours, he responded to calls to people in every rank of life, both white and colored. He did a lot of charity work and, in his quiet, unassuming manner, helped to improve the lot of many underprivileged people.

There is in every community a person to whom others turn for guidance and advice, and often this person is the family physician. Such was the case with Dr. Harper. He merited the confidence of his friends and patients, considered not just the profit side of life, but the human side, and helped to brighten the road of the unfortunate. He gave without stint the best efforts of his life in the service of others.

He and I have practiced in the same small town for nearly 50 years, and have always been good friends, never any jealousy or envy between us. And I have never seen a man more devoted to his family and home, more loyal to his church and profession, or more conscientious in his dealings with his fellowman.

The memory of his life among us will remain as an inspiration for years to come.

F. S. Rogers, Com.

Randolph-Terrell Medical Society

The Use of Reinforcing Metallic Mesh Gauze in the Repair of Large Postoperative Ventral Hernias

THOMAS J. FLOYD, JR., M.D., Griffin, Ga.

SINCE THE EARLIEST inception of my surgical career, the repair of the various types of hernias has been an intriguing subject. They all present surgical problems which at times seem insurmountable. Each case must be individualized according to the abdominal wall defect, and the surgical technique most adaptable to each individual case must be instituted. Over the years, many surgeons have improvized or modified various techniques in an effort to reduce the high rate of recurrence. Then too, hernia repairs are frequently delegated to inexperienced surgeons who lack fundamental foresight and surgical training to justly attempt repair. One frequently forgets that a hernia recurrence is a disfiguring and disabling defect which can have far reaching repercussions during these days of industrial employment. The subject of hernias should be approached with serious consideration and careful attention to technical details. Over the past 20 years, great strides have been made in the repair of inguinal hernias. This advance has been made primarily through the reappraisal of the anatomy and physiology of the inguinal canal, careful consideration of well known fundamental surgical principles and the use of antibiotics in the prophylaxis of infections. However, in my opinion, relatively little progress was made during this same span of time toward correction of the large postoperative abdominal wall defects, which are usually found in the senile, obese, poor risk patient. These defects frequently reach alarming proportions and cause extreme disability. Many well-known surgical techniques have been devised and widely used. The alarmingly high rate of recurrence was sufficient evidence to suggest that the standard repairs of these defects were not satisfactory, and that another approach was desired. The addition of mesh wire gauze to the surgical armamentarium for repair of these large abdominal wall defects is, to my mind,

the greatest advance in hernia repair during my entire medical career.

The use of reinforcing metallic materials in the repair of hernias is not new. Many types of materials have been used and for one reason or another have been discarded. Phelps¹ (1894) repaired many large inguinal hernias by the use of coiled wire placed in the floor of the inguinal canal. Witzel² (1900) constructed in the tissues a crude filigree by the use of a crosswork of silver wires, suggesting to the surgical world the use of a ready made filigree. Goepel³ (1900) as the first to make use of this ready made filigree. Meyer⁴ (1902) resorted to the use of a silver wire mosquito-bar like netting. Bartlett⁵ (1903) use a filigree of silver wire loops. All of these appliances were usually made of rigid silver wire¹² which caused the patient discomfort, and the rigid wire was subsequently discarded. Wound infections usually developed, and, with the metallic implants in place, prolonged drainage occurred. However, eventual healing by scarring was the rule, and many hernias previously considered inoperable were cured. The use of these materials gradually fell into disuse for three⁶ main reasons:¹² (1) associated discomfort to the patient, (2) silver wire appliances and sutures are ill-suited for tissue implantation because silver is not inert and rapidly work hardens and (3) a distaste for foreign bodies in the tissues.

Because of the wide and successful use of tantalum in war wounds, in the form of skull plates and other devices, the use of this material in reinforcing abdominal wall defects was considered. Tantalum gauze is the result of this investigation. Much of the original investigation was done by Dr. Amos Koontz, of Baltimore, who in 1947 made his presentation before the Southern Medical Association in Atlanta. After hearing this most absorbing presentation I felt that here was the answer to my surgical dilemma of 20 years duration.

Since that date the use of this and allied materials has become widespread with many excellent reports

Presented before the Griffin-Spalding County Hospital Staff, April 20, 1954.

appearing in the medical literature. These materials are not recommended for use in the ordinary hernia which may be cured by many conventional methods; they are reserved for those hernias which were formerly considered nonoperable, or if operable the chance of cure unlikely. To condemn these unfortunate people to a life of perpetual physical handicap is contrary to one's better principles. Therefore, it behooves us as surgeons to accept these poor risk, senile, obese, physically degenerated patients with large incapacitating ventral hernias as a personal challenge in our effort toward useful rehabilitation. It is sometimes surprising what can be accomplished.

Before considering the physical properties of the inert materials most widely used, I would like to briefly review the more common reasons these hernias recur. They are:⁷ (1) closure of the abdominal wall under tension, (2) postoperative wound infections, (3) postoperative haematomas, (4) attenuated or weakened musculo-fascial tissues, (5) obesity and (6) middle age. Among people over 50 years of age it is frequently reported⁷ the incidence of recurrence of direct inguinal hernias is 38 per cent and for indirect inguinal hernias 30 per cent.

Of all the recurrent factors to be considered, wound tension is the most important. It is a well known surgical principle that any suture, regardless of the material, placed in tissue under tension will cut through; this itself is cause enough for recurrence. Therefore, closure of large defects in the abdominal wall is seldom successful by the more commonly accepted techniques formerly in use. Fascia flaps and relaxing incisions only add to the previously weakened abdominal wall which has already proven inadequate. The use of some type of inert material as a "patch" over such abdominal wall defects is a logical method and a simple operative procedure which provides the patient with a remarkably high rate of cures.

The ideal material for such implantation in the abdominal wall must be criticized by the following criteria, as suggested by Preston:⁷ (1) biologically non-irritating in tissues; of inorganic material, (2) easily sterilized and not altered by sterilization; (3) chemically inert in tissue fluids; (4) pliable, non-rigid to adjust with tissue movement; (5) strong, to withstand local stress and intra-abdominal pressure; (6) non-electrolytic; (7) workable, not subject to fragmentation and becoming "work-hardened"; (8) available and inexpensive; (9) non-hydroscopic and (10) non-opaque to x-ray.

There are three materials now in vogue, each of which is woven into fine 50 x 50 mesh gauze from strands of 0.003 inch in diameter, supplied in sheets of 6 x 12 inches. Two of these materials, tantalum and stainless steel alloy (surgaloy), are commonly

used, and the third, fiber-glass, has not found widespread use—principally due to physical disadvantages of the material and a slightly irritating effect on the tissues.

In all of these materials the strength of the hernia repair does not depend entirely on the physical properties, *per se*, of the materials used, except in the very early stages of healing. The mesh acts as a fascia grid in which thousands of strands of connective tissue grown between the mesh adding great strength to the abdominal wall. Eventually through the constant give and take of the abdominal wall the gauze usually hardens and undergoes fragmentation as evidenced by postoperative x-rays. All authors reviewed feel that this fragmentation is of no significance as these fragments are enclosed in a new aponeurosis toughened by thousands of metallic transplants. However, in my opinion this is a distinct disadvantage in the materials used today. Here I feel is a challenge to our present day metallurgist to supply us with a new, more versatile material which will fulfill all the criteria as outlined by Preston.⁷

A brief consideration of the physical properties, the clinical advantages and the clinical disadvantages of tantalum and stainless steel alloy is now in order.

Tantalum is an element with an atomic number of 73 and an atomic weight of 180.88. It possesses both tensile strength, ductility and malleability. It has a high degree of tissue acceptability and is biologically inert; tissue repair proceeds rapidly and in an orderly manner⁶ with a minimum of interference. It can be used with impunity in the presence of massive infection. It satisfies all of Prestons criteria⁷ except that it becomes "work-hardened," is subject to fragmentation, is opaque to x-ray and does not have sufficient tensile strength in hair-like strands.

Stainless steel alloy gauze possesses the same clinical adaptability to hernia repairs that tantalum gauze possesses and it perhaps possesses some advantages in physical properties. It has greater tensile strength and resists fragmentation more efficiently than tantalum gauze, therefore, perhaps offers a distinct advantage in its clinical application. Then too, the cost of this material is correspondingly less than the tantalum gauze. Stainless steel alloy gauze possesses all the criteria as stated by Preston except that it is opaque to x-ray and possesses some property of fragmentation. However, both of these materials are acceptable and are interchangeable except for the points previously mentioned.

The literature reports a remarkably low rate of recurrence. Koontz⁸ reports 134 cases of large ventral and difficult inguinal hernias with one recurrence. Preston⁷ reports 248 hernias of all types in which stainless steel alloy and fiber-glass was used with no recurrences. Lam⁹ reported 24 cases with no

recurrences. Throckmorton¹⁰ reports 15 cases with no recurrences. Since publication of these papers many more cases have been added, too numerous to mention.

Following is an analysis of a series of 14 cases dating from May 1950 through March 1954 in which adequate follow-up was obtained. These were all private cases done jointly by my colleague and myself. The criteria used in the selection of these cases were that prior to Koontz's publication of the use of reinforcing metallic mesh gauze in hernia repair, in 1947, all of these cases would have been declared nonoperative or if operative that chance of cure was considered less than 50 per cent. They would then have been doomed to the perpetual care of an inadequate abdominal support to become gradually more disabled and non-remunerative with each advancing year.

The age group is between 31 years and 73 years, an average age of 52 years. Sex: There were four males and 10 females. Race: There were 13 whites and one colored. Types of hernias: There were four upper abdominal hernias, each following a cholecystectomy, two with a split rectus incision and two with a transverse incision. There was one recurrent inguinal hernia. The remaining nine were subumbilical in character. Of these nine, three were post-appendectomy—each of which followed a split rectus incision; six were post-pelvic surgery—all following mid-line incisions. Out of 14 selected cases there is one recurrence, or 7.14 per cent. There were no deaths in this series.

The following four cases are typical of the hernias repaired in this series.

Case Report No. 1

Race: White
Sex: Female
Age: 43
Hospital number: 15,417
Brief History: A large sub-umbilical, postoperative, ventral hernia subsequent to a pelvic laparotomy one and one-half years previously. Apparently, immediately postoperatively, she eviscerated as she was anesthetized and sewed up. Subsequent to her discharge from the hospital, she began to develop a mass of increasing proportion at the site of her previous laparotomy.
Physical Findings: Obese female. Abdomen: A long sub-umbilical midline scar which extends from the symphysis pubis to the umbilicus beneath which is a large fascia defect extending the entire length of the scar. There is a ventral hernia present which is approximately the size of a very large grapefruit. It is easily reducible, shows no evidence of strangulation.
Type of Surgery: Postoperative Ventral Hernioplasty, using Tantalum mesh wire as reinforcing suture material.
Date of surgery: 5-4-50. Immediate postoperative complications, none. Follow up to date shows no recurrence.

Case Report No. 2

Race: White
Sex: Female
Age: 64
Hospital number: 1284
Brief History: Twenty years previously was subjected to a

pelvic laparotomy and subsequently developed a large postoperative, sub-umbilical ventral hernia which is of increasing size, causes tremendous debilitation with frequent ulcerations of the skin overlying the apex of the hernia. She is unable to wear a supporting belt. She is a known cardiac and has had auricular fibrillation for many years.

Physical Findings: There is a large football size postoperative, sub-umbilical ventral hernia present with a tremendous fascia defect that will easily admit the two fists. There is no evidence of strangulation, and there are small superficial ulcerations of the skin, most prominent at the apex of the hernia.

Type of Surgery: Postoperative Ventral Hernioplasty, using Tantalum mesh wire as reinforcing suture material.

Date of Surgery: 5-10-51. Immediate postoperative complications, possible embolic phenomenon to left common iliac artery. Otherwise, none.

About two months after hernioplasty this patient fell and experienced sharp pains in the lower abdomen. She soon noticed evidence of local recurrence with the hernia rapidly increasing in size. The recurrence is larger than the original hernia. The fascia defect is enormous. The overlying skin is very thin with individual coils of small bowel easily visualized. The skin's surface shows several small areas of ulceration. She is afraid the "skin will give away," and I too share this fear. I feel that another attempted repair is imperative.

Case Report No. 3

Race: White
Sex: Female
Age: 52
Hospital number: 10,490
Brief History: Pelvic laparotomy 15 years previously. Immediately postoperatively developed a respiratory infection and had a severe bout of coughing. Subsequently developed a large sub-umbilical defect. A hernia was evident, and it has been increasing in size over the past years until now it is disabling. She gets about with difficulty and cannot wear an abdominal support. There is marked obesity, and I advised her to lose 75 pounds over the period of one year. She has complied with the request.
Physical Findings: Moderately obese female. A large sub-umbilical midline fascia defect at the site of previous surgery. Fascia defect will admit both fists. The hernia is about the size of a football.
Type of Surgery: Postoperative Ventral Hernioplasty, using Tantalum mesh wire as reinforcing suture material.
Date of Surgery: 3-23-53. Immediate postoperative complications, none. Follow up to date shows no recurrence.

Case Report No. 4

Race: White
Sex: Female
Age: 70
Hospital number: 9857
Brief History: Many years ago was submitted to a cholecystectomy. Soon afterwards developed an incisional hernia, which only in the past two or three years has increased in size. It is now incapacitating in that upon standing, it causes severe pain and pressure. At first she was advised to wear an abdominal belt which was not satisfactory. Over a period of six months observation, the hernia rapidly increased in size and some type of corrective surgery was imperative.
Physical Findings: Moderately obese and senile. Moderate peripheral arteriosclerosis, hypertension, avitaminosis. A large right upper quadrant, muscle splitting type of incision extending from the costal margin to below the umbilicus. Large football size hernia mass present, containing many coils of small bowel, is only partially reducible. Fascia defect will admit approximately six fingers.
Type of Surgery: Postoperative Ventral Hernioplasty, using Tantalum mesh wire as reinforcing suture material.
Date of Surgery: 2-12-53. Immediate postoperative complications, none except for serous drainage in wound. Follow up to date shows no recurrence.

I believe the successful repair of my only recurrence may be obtained by the use of mesh gauze and applying the "box top closure" as described by Rush and Rush¹¹ in which the peritoneal sac is utilized

to give substance to four flaps which are advanced diagonally to cover the defect just as the end of a paste board box is closed by four overlapping flaps. Certainly the recurrence as it exists today in this most unfortunate woman is miserable and incapacitating and is worthy of another effort—she has little to lose.

Summary

In summarizing I wish to emphasize that a new material has been added to our surgical armamentarium which will offer a reasonable certainty of cure of these large abdominal wall defects in these senile, obese, physically degenerated, miserable patients. It behooves us as surgeons to tackle this problem with fortitude for we have much to offer in the present stages of modern surgery and anesthesia. I feel that fragmentation and work-hardening are distinct disadvantages in the materials used today. Had not fragmentation occurred, my one recurrence to date might have been a successful cure. We must challenge industry to provide us with a satisfactory material—a challenge that I hope will not go unanswered.

232 West Taylor Street

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Rabies in Georgia

RABIES AMONG DOGS is lower than any time in the state's history. Thanks to the combined efforts of Georgia veterinarians, county boards of health, and State Health Department sponsored rabies clinics.

The state had a phenomenal drop in rabies last year. Only 81 dog heads were found to be infected on examination by State Health Department Laboratory personnel, whereas the heads of 230 dogs were found to be rabid in 1953.

T. F. Sellers, state health department director, says that more emphasis should be given to the control of rabies among foxes and cattle because there are now more rabid cattle and foxes in Georgia than rabid dogs.

"When fox rabies is prevalent in an area," he says, "state and county health departments try to stimulate interest in dog vaccination programs. Since rabies is primarily a dog's disease, the first measure to be taken is the vaccination of dogs. This tends to protect both dogs and livestock. Serious problems involving dogs and wildlife require appropriate action by county officials and the U. S. Fish and Wildlife Service personnel, who reduce the wildlife population

by trapping. In some sections of the country rabies among other forms of wildlife—such as skunks, wild bobcats, and raccoons—is a more serious problem than among either dogs or foxes.

Dr. Sellers says that county boards of health perform an important role in rabies control by getting rid of stray dogs. He says that open garbage dumps present "a whale of a problem" because stray dogs congregate at these dumps and eat.

"It is our practice," Dr. Sellers says, "to encourage dog vaccination and dog control throughout the state but to concentrate our efforts in known infected areas. If this does not control the disease the county may request state assistance."

At the present time, the bulk of dog rabies exists in South DeKalb, South Fulton, Clayton, and Henry Counties. Elsewhere in the state, fox rabies is a greater problem. Only one person in Georgia—a four-year-old Barrow County boy, died of rabies last year. Circumstances of the exposure could not be determined satisfactorily.

While the rabies situation is improving, constant vigilance is urged to prevent its recurrence.

Effective Lung Ventilation of Normal Subjects in the Mechanical Respirator

J. H. U. BROWN, Ph.D., Emory University, Ga.

THE MECHANICAL respirator (iron lung) is widely used in this country. The literature contains many reports on the care of respirator patients,^{3 4 7} but there are few definitive reports on the regulation of respiration by this instrument. It is obvious that gross clinical signs such as cyanosis are not adequate indications of lung ventilation. Moreover, the relative acidosis or alkalosis which develops in over or underventilation can be determined only by elaborate clinical tests.

From the standpoint of the patient, the measurement of minute volume is not an adequate test in that respiratory dead space, and rate of breathing may affect the amount of oxygen reaching the alveoli with no detectable change in minute volume. The tissues of the patient may be anoxic with a minute volume which is considered normal. Another important consideration in the determination of rate of respirator operation is the amount of work required of the patient.

In order to clarify some of these questions, 100 tests on normal human subjects have been performed. Clinical cases have not been included in this series because it was felt that until norms of breathing rate and depth of respiration could be established for optimum respirator operation little information could be carried over to the patient.

Methods

During a previous study a method was developed for the collection and assay of separate fractions of lung air¹. This apparatus was used successfully to partition any single expired breath into as many as seven separate fractions and to collect each fraction separately. In addition, the process could be repeated for any number of consecutive breaths. As a result, the volume of tidal air, the velocity of air

flow during any portion of the respiratory cycle and the carbon dioxide level could be accurately determined for each fraction or, in other words, for each increase in lung depth.

In order to accomplish the desired result, a Drinker whole body mechanical respirator¹ was modified to provide carefully controlled pressures² within the chamber. A mechanical drive and valve was devised to partition the expired air.² The respirator could be set to operate at 6, 12, 15, and 20 respirations per minute (R) and at negative pressures of from zero to 50 cm. of water.

One hundred tests were run on three male and two female subjects. The minute volume, dead space, pattern of inhalation and exhalation and the tidal volume were determined at varying combinations of rates and specific pressures.

Results

The data in Figure 1 demonstrate clearly that at any given speed of respiration the tidal volume and therefore the minute volume is dependent on respirator pressure. An increase in pressure increases the tidal volume. A doubling of the pressure almost doubles the minute volume. At a pressure of about

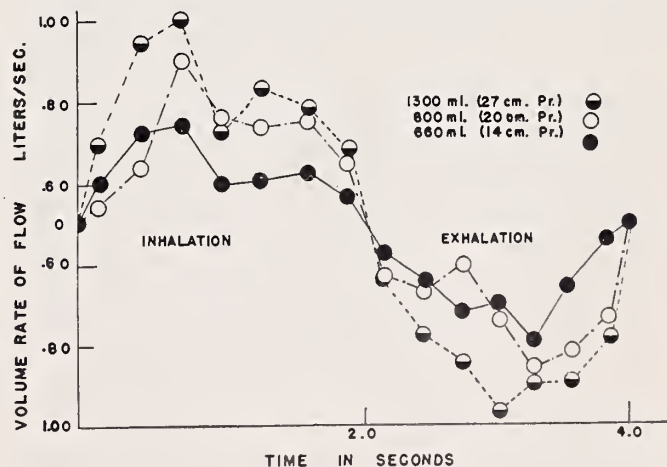


Figure 1

The relationship between the rate of flow of air from the lungs of a subject and the negative pressure applied by the respirator during a single respiratory cycle. Effects are due to changing pressure at a constant speed (15 R). Tidal Volumes are indicated in milliliters.

From the Dept. of Physiology, Emory University School of Medicine.

1. The mechanical respirator was a tank type supplied by the Warren Collins Co.

2. The word "pressure" as used here refers only to NEGATIVE pressure. The symbol "R" is used by convention to designate Respirations Per Minute.

14 cm. of water, the subject is able to breathe independently of the respirator. In general, the normal tidal volume of a subject can be obtained at a pressure of about 18 cm. of water. As the dead space remains essentially the same⁶ for a given speed of respiration, the effective ventilating volume (tidal air—dead space) increases with increasing pressure.

On the other hand, at the same pressure, an alteration in speed produced marked alterations in tidal volume. The data in Figure 2 show that as the speed of respiration increases, the tidal volume decreases if the pressure remains the same. This occurs because of purely mechanical reasons. The longer time that any given pressure is maintained by the respirator the greater will be the final tidal volume. Faster speeds then do not allow the pressure to build up or be maintained for appreciable periods and the tidal volume is low.

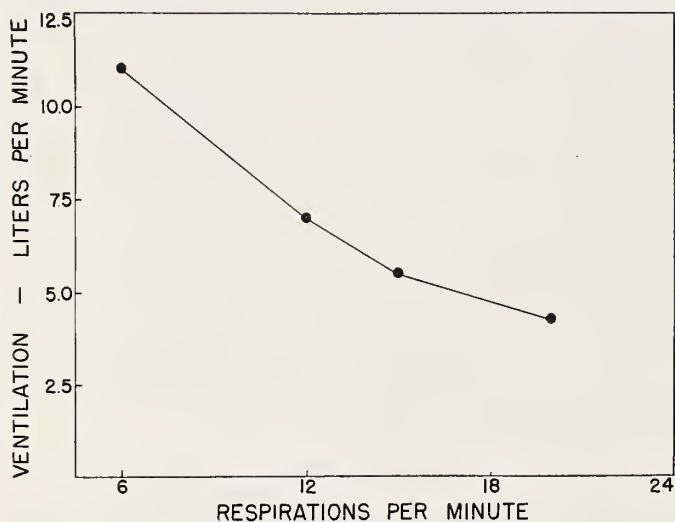


Figure 2

The relationship between tidal volume and respirations per minute at a constant respirator negative pressure (20 cm. water).

The two figures mentioned above illustrate an important point in the use of the respirator. The patient was better ventilated under those conditions in which the speed is slow and the pressure high. High speed and low pressure prevent effective ventilation. There is an optimum point. The use of low speeds and high pressures produces a ventilation far above the needs of the patient and may lead to severe metabolic upsets as a result of decreased blood CO_2 tension. A rate and pressure should be selected which is somewhere near the normal pattern of the individual. Both by objective measurement of the ventilation and by subjective statement of the patient the best operating point appears to be 15 R at a pressure of 18 cm. of water.

It is easy to produce conditions in the respirator which are not physiological. Figure 3 presents data obtained in unphysiological circumstances. These data clearly demonstrate the excess output of CO_2 when the speed of the respirator was lowered and

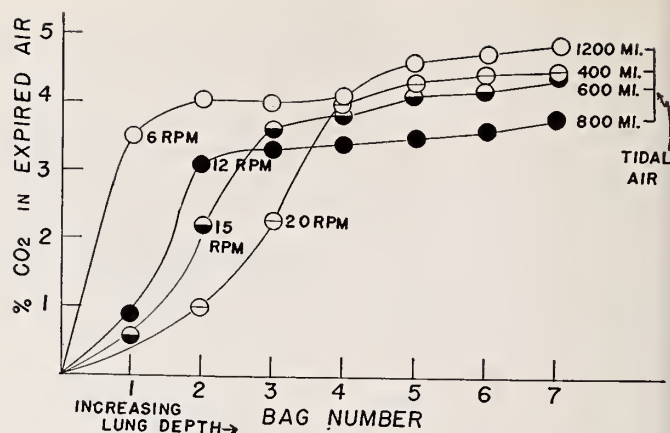


Figure 3

The relationship between the amount of CO_2 exhaled and the portion of the expiratory cycle from which the gas was collected. Results were obtained at a constant pressure of 20 cm H_2O at the indicated speed. The seven collections were made over equal time intervals.

the accumulation of CO_2 as the speed was raised; all with the same pressure in the chamber. It is true that the CO_2 output at 20 R could be brought up to normal by increasing the pressure to 30 cm. of water, but this in turn is extremely uncomfortable for the patient. The decrease in effective lung ventilation is apparent when it is considered that the dead space of 130 ml.⁶ remained the same while the tidal volume was altered from 1000 ml. (12R) to 400 ml. (20R).

In general, a respirator should be designed for maximum ventilatory efficiency and minimum work on the part of the patient. Otis et al⁶ have demonstrated mathematically that an increase in ventilation above 15 liters per minute requires the use of the muscles of expiration. They further conclude that less work is required in terms of calories if the ventilation is about six liters per minute at a rate of 15 R. Rates above and below this value are much less efficient and require the expenditure of large amounts of energy.

Summary

The effect of pressure and speed of the Drinker Mechanical Respirator on the effective ventilation of normal subjects has been evaluated in 100 tests. It is concluded that a speed of 15 R with a negative pressure of about 18 cm. of water is probably a near optimum combination to effect normal gas exchange in adults.

Emory University School of Medicine

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Precocious Puberty

Report of a Case in a Female Infant

W. S. CLIFFORD, M.D., Columbus, Ga.

PUBERTY IN THE female is characterized by the onset of menstruation, enlargement of the breasts, darkening of the areola, presence of axillary and pubic hair, and certain psychological changes. The average age is between 10 and 12 years. Precocious puberty is defined as the onset of the above phenomena below the age of nine years. Precocious puberty falls into two groups: (a) that due to neoplasm of the endocrine glands, and (b) the constitutional type, as defined by Novak. The differentiating point between these two is ovulation, which occurs in the constitutional group, and will be discussed later.

Neoplasms Causing Precocious Puberty

1. *Pineal Tumors*: They hold no gynecological significance. In 177 cases reported by Bing, Globus and Simon, only one pineal tumor was found in a female.

2. *Pituitary Gland*: There are no known cases reported in the literature of pituitary tumors associated with precocious puberty. This is somewhat surprising since the pituitary gland has often been spoken of as the "master gland" of the body, and its direct relationship to normal menstruation, including all its facets, has long been known.

3. *Adrenal Cortical Tumors*: These tumors are defeminizing, and are associated with pseudohermaphroditism. They may cause precocious puberty in early childhood in either sex. The clinical characteristics are those of masculinity in the female, such as hirsutism, voice changes and hypertrophy of the clitoris. Precocious menstruation is rarely associated with these tumors occurring in female childhood. Its rarity is in marked contrast to the granulosa cell tumor of the ovary.

4. *Ovarian Tumors*: Ovarian tumors, however, do produce precocious puberty. Granulosa cell and theca cell tumors are "feminizing" tumors causing precocious menstruation of the anovulatory type (estrogen induced), enlargement of the external genitalia, upper genital tract, and simultaneous growth of pubic and axillary hair.

By far, the most common functioning tumor is the granulosa cell tumor. Its development has been ob-

served at various ages in life, the majority reported in women past the menopause (Bickel and Bennett¹). There maybe a return of periodic menses; an increase or return of sexual activity; a general sense of well-being, or mental buoyancy; improvement in skin texture of the vulva; an increased thickness of vaginal mucous membranes; and other features associated with estrogenic stimulation.

Lull² reported only 16 cases in the literature of granulosa cell tumors responsible for precocious puberty. He added two of his own cases to bring the total to 18.

One child was nine months old, four months younger than the youngest recorded case. These are always dramatic cases in the very young. They present the usual clinical pattern associated with the onset of the female sex hormones of later life.

When these tumors occur in the child-bearing age, profuse menstruation is often the only symptom noted. In the childless couple the tumor may be the etiology of sterility due to anovulatory cycles. Amenorrhea rarely is associated with the tumor.

Granulosa cell tumors like other dysontogenic and embryonal neoplasms have a high potential for malignancy (12 to 28 per cent according to current reports), and they have also been found associated with adenocarcinoma of the fundus in the post-menopausal patient in about 0.5 per cent, according to Emge.³

Theca cell tumors are less common than granulosa cell tumors. The feminizing features are identical in both tumors and therefore cannot be differentiated clinically.

It has been estimated that 60 per cent of the estrogen producing tumors occur in the menopause phase; about 30 to 35 per cent are discovered in the child-bearing years; leaving approximately five per cent in pre-pubertal years. Theca cell tumors do not occur before puberty, according to Speed,⁴ however, Gordon⁵ reported a case of theca cell tumor in a child one year old. He also reported the oldest case to be 92 years old.

Histo-pathology of the granulosa cell tumor resembles the granulosa cell layer of the ovarian follicle. At one time, many workers believed the histogenesis to be from ovarian mesenchyme. Grossly, they are often small grayish tumors found in what otherwise appears as normal ovarian stroma. This

Presented before the Section on Obstetrics and Gynecology, 104th Annual Session of the Medical Association of Georgia, May 4, 1954.

bears out the profound biological and physiological potency of these tumors. Others are grayish-brown and lobulated, replacing the entire ovary, and on occasions may be yellow, due to luteinization. They are often cystic.

The histogenesis of the theca cell tumor remains unsettled. Novak⁶ and others believe the histogenesis to be in common with the granulosa cell tumor since many of them are an admixture of theca and granulosa cells. However, some of the tumors are composed entirely of theca cells; consequently, they should be considered a separate group. That steroid substances originate in the thecal layers of the Graffian follicle and not in the granulosa cell layers was demonstrated by McKay, Robinson and Hertig.⁷

Constitutional Type

Finally, Novak⁸ reported nine cases of the constitutional type of precocious puberty, the youngest 15 months, the oldest seven and one-half years old.

This type of precocious puberty means the complex mechanism of puberty simply has its onset at an earlier age than the average of 10 to 12 years. The dividing line is nine years, and some workers believe that eight years, or below, should define precocious puberty with all its signs and symptoms, as mentioned above.

The constitutional type has no demonstrable cause, while there may be an obvious etiological tumor in the other group. Nor does the constitutional type jeopardize the remaining menstrual life by cessation at an early date; nor do tumors of the endocrine glands develop later; this is believed to be true because many have been followed over a period of years by Novak.

Precocious puberty of the constitutional type or that due to ovarian neoplasms can only be differentiated by microscope demonstration of evidence of ovulation. The typical example of the constitutional type is Lina Medina, of Lima, Peru, who, at the age of five years, eight months, gave birth by cesarean section to a full term pregnancy in 1940. She is clearly the youngest mother in medical history.

Furthermore, following removal of the functioning ovarian neoplasm in a menstruating infant, there is no recurrence of menstrual periods; there is permanent regression of the breasts and genitalia until such time as the normal pubertal age is reached. This does not happen in the constitutional type.

Management of Precocious Puberty

Those due to neoplasm require surgical removal. The secondary sex characteristics disappear when the source of hormones has been removed. In some instances, the constitutional type of precocious puberty must submit to exploratory laparotomy since often the functioning tumors are small and discrete. Examination of the tissue will classify the true grouping.

These little patients must be protected against sex violation. The constitutional group presents the gravest problem due to the ovulatory mechanism, since pregnancy can ensue.

The third point of importance in the latter group is one of psychological management by careful and considered explanation. Furthermore, these children need reassurance that this early onset of the menstrual flow will not set them apart with the fear they are abnormal. This pressure will be somewhat alleviated by the time the child reaches the average expected age of puberty by association with other young girls who have attained that stage in life.

Case Report

Patient is a 22 month old female infant who weighed seven lbs., 12 ozs. at birth by normal spontaneous delivery, on 1-7-51. Patient was referred on October 10, 1952. Mother relates infant is having a menstrual period consisting of painless bloody discharge which began four days previous to examination, requiring a change of under-pants three to four times daily since onset. No history of previous illness or similar "menstrual periods."

Examination reveals a normal white female infant of approximately stated age of 22 months. Breasts bilaterally show increase in size with pronounced dark color change in areola. Abdomen reveals a four to six cm. smooth round mass in right lower quadrant, freely movable, and non-tender.

Pelvic: External genitalia show definite enlargement with a fairly well developed clitoris for an infant. Both labia are hypertrophied. Introitus admits a Kelly speculum; cervix is several times larger than normal and menstrual blood flows through the clean external os. The introitus admits the examining finger with ease. Fundus and cervix markedly above normal size and congested, approximately six cm. in size.

Adnexae:

Left: Clear

Right: A smooth oval cystic mass approximately four to six cm. in diameter, freely movable.

Laboratory:

- 1) Blood and urine: normal limits
- 2) Mack's Stain (Vaginal) three plus
- 3) I. V. pyelograms within normal limits

Pre-Operative Impression:

- 1) Precocious puberty, 22 month old infant
- 2) Estrogenic producing ovarian tumor.

10-13-52 Operation: Through a lower abdominal mid-line incision the fundus is seen as markedly enlarged, approximately 5 x 3 cm. and soft. Both tubes normal except for marked hypertrophy measuring 5.0 x 0.5 cm. Left ovary 1.0 x 0.5 cm., apparently normal. The right ovary 4.5 x 2.5 cm. in size, cystic, and free in the pelvis. The right tube is very closely adhered to the ovarian tumor. The appendage and ovary were removed. Abdomen closed in the usual fashion.

10-14-53 Pathology:: Dr. Ralph Monaco; Luteinizing granulosa cell tumor, right ovary.

12-14-52 Post Operative Examination: Mother states baby has had satisfactory convalescence, vaginal bleeding stopped. On examination the abdominal incision is well healed. Breasts are flat, areola light colored, and external genitalia are involuted. Introitus no longer admits the finger. Rectal confirms uterine involution. No recurrence of above symptoms in one and one half years.

Final Diagnosis:

- 1) Precocious Puberty
- 2) Granulosa Cell Tumor

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VACCINATION AGAINST POLIOMYELITIS

THE PREVENTION OF paralytic poliomyelitis by immunological means now appears practical and effective. This achievement has resulted from the accumulation, consolidation and integration of a mass of fundamental scientific data acquired over a 17 year period. The results obtained in these basic investigations have led to new concepts in the pathogenesis of poliomyelitis and certain technical advances which assure the eventual success of vaccination against poliomyelitis.

It seems worthwhile to recall, though not necessarily in chronological order, some of the more significant developments which have led to the swift advances in knowledge related to poliomyelitis. The recognition of the fact that only three major and distinct types of poliomyelitis virus need to be considered in the development of a preventive agent was a major step. The general distribution of these three types, the absence of effective cross immunity, and the ability of each of the types to produce paralytic poliomyelitis made it necessary to afford protection against all three viruses in order to be effective. The cultivation of each of the three types in tissue cultures of non-nervous origin provided a notable technical advance which allowed an abundant supply of virus and lent support to the hypothesis that the poliomyelitis viruses were not strictly neurotropic.

The generally accepted concept that the vast majority of human infection occurs as a primary infection in the alimentary tract was derived in large part from extensive epidemiological investigation. Such infection without obvious central nervous system involvement was followed by the formation of type specific antibody and active immunity. The significance of type specific antibody was apparent soon after recognition of the occurrence of viremia prior to the onset of paralysis. This discovery led to experiments in which the prevention of paralysis by administration of small amounts of passive antibody was accomplished without necessarily eliminating the alimentary infection and its resulting immunity. Thus a coherent pattern to the pathogenesis of poliomyelitis was formed by which could be predicated an approach to the prevention of paralysis in poliomyelitis.

The development of practical methods for immuni-

zation against poliomyelitis has been based on the assumption that such immunity is mediated through the action of antibody. Two seemingly divergent approaches to active immunization have been followed by investigators. One approach utilizes live, modified virus administered by a natural route in an attempt to mimic naturally occurring infection without the paralytic component. The other consists of the parenteral administration of virus which has been subjected to chemical treatment with formalin.

The proponents of the live, modified vaccine believe that an effective and prolonged immunity can best be obtained by virus with a low or absent neurotropic effect which has retained good antigenic potency. Experiments are now in progress with several live vaccines which contain virus modified by different means. One such vaccine consists of chimpanzee-avirulent mutants of all three virus types grown by tissue culture in monkey kidney cells. Dr. Albert Sabin recently reported the results of oral administration of this vaccine to 26 young adult volunteers who did not have demonstrable circulating antibodies against the virus prior to vaccination. Following inoculation, antibody production to all three virus types was stimulated without clinical evidence of illness. More extensive clinical trials will be necessary before the safety and effectiveness of such immunization procedures can be evaluated. Nevertheless, the apparent stability of the chimpanzee-avirulent mutants and the results of investigation in animals lends encouragement to the hope that such live vaccines may be practical in man.

On April 12, 1955, the evaluation of a formalin treated vaccine, the so-called Salk vaccine, was reported. A field trial which utilized 1,829,916 children either as vaccinated subjects or as controls had been conducted during 1954. This extremely impressive and detailed study revealed that although certain of the lots did vary in immunizing potential, the vaccine did lessen the development of paralytic poliomyelitis. In the carefully evaluated placebo-controlled areas the vaccination was found to be 80-90 per cent effective against paralytic poliomyelitis. Against disease caused by Type I virus, it was 60 to 70 per cent effective, and 90 per cent effective against that of Type II and Type III virus.

In these studies 18 different lots of vaccine were used. The strains selected to represent Types I, II, and III virus were respectively the Mahoney, MEF-I, and Saukett strains. Each of the strains had been

grown separately in roller tube tissue cultures of monkey kidney cells, harvested and treated separately with 1:4000 formalin. (The formalin treatment produces a more rapid rate in the destruction of infectivity than in the decline of antigenicity. Cessation of chemical treatment may therefore be brought about at a point where antigenicity is retained and detectable infectivity has disappeared.) After neutralization of the formalin, the virus from the strain pools of each of the three types was pooled in equivalent amounts. Each lot of vaccine so prepared was subjected to the "Specifications and Minimal Requirements" established by the Vaccine Advisory Committee of the National Foundation for Infantile Paralysis. Each lot of vaccine before use in human beings was subjected to tests for the presence of B virus, lymphocytic choriomeningitis virus, for bacterial sterility, and for antigenic potency. In three separate laboratories (the laboratory of the manufacturer, the laboratories of Biologics Control of the National Institutes of Health, and the Virus Research Laboratories at the University of Pittsburgh) each lot was tested for non-infectivity. The non-infectivity tests in each laboratory consisted of the inoculation of 18 monkeys (12 intracerebrally and six intramuscularly) and the inoculation of a battery of tissue culture tubes containing monkey kidney cells. It was felt that, for a lot which met these "Specifications and Minimal Requirements," the possibility of infectious activity remaining had been reduced to a point below which it could not be measured by practicable laboratory procedures.

In anticipation of the favorable results from the field trials, the National Foundation for Infantile Paralysis contracted with six pharmaceutical manufacturers in order that the vaccine would be ready for use in the Spring of 1955. Following announcement of the results of the field trial, the vaccine was promptly licensed for sale and use. After the licensing of the vaccine, the responsibility for sterility tests and tests of non-infectivity reverted to the manufacturer. As with other such products, the manufacturer is required to submit a detailed protocol describing production and testing of each lot of vaccine. The protocols are reviewed by the staff of the National Institute of Health and approved prior to the release of each lot for distribution. In addition, random samples of the manufacturers' product are tested at the National Institutes of Health.

At the time of preparation of this editorial, about 6,000,000 school children had been inoculated with vaccine in the 1955 program. Among this group

a total of 62 cases of poliomyelitis had developed of which 59 had paralysis. Of the 62 cases, 51 had received vaccine produced by Cutter Laboratories; 10, vaccine of Eli Lilly Company; and one, vaccine from Wyeth Laboratories.

On April 27, 1955, the Cutter vaccine was withdrawn from the market. The Surgeon General of the United States Public Health Service halted the release of all vaccine on May 7, 1955, and recommended that all states and municipalities postpone their vaccination programs. The association of the Cutter vaccine with such a large percentage of the cases of poliomyelitis developing during the vaccination program appears to be more than mere coincidence, whereas those cases associated with other vaccines fall within the expected incidence of naturally occurring poliomyelitis for these groups. The uniqueness of the Cutter vaccine has not been satisfactorily explained.

Without attempting an explanation of the association of the Cutter vaccine with the occurrence of poliomyelitis, it seems worthwhile to note that man is possibly more susceptible to infection with the poliomyelitis virus than is either the monkey or the tissue culture used in the routine tests of the vaccine for non-infectivity. Furthermore, the reproducibility of the results obtained by evaluation for non-infectivity in a single laboratory have not been clearly defined. Pertinent to this point would be data undoubtedly gathered during the selection of the 18 lots of vaccine used in the 1954 vaccine field trial. It would be of interest to know the total number of lots of vaccine screened in this selection and the number discarded because of detectable live virus. Of prime interest, however, would be actual number of lots which were eventually discarded that had passed tests for non-infectivity in at least one of the three evaluation laboratories. It is obvious that many aspects of the problem concerning the Cutter vaccine, including production methods, must be subjected to close scrutiny before an explanation can be forthcoming.

It is indeed unfortunate that public concern has been enhanced by the arbitrary, and at times contradictory, statements which have been issued in regard to the status of the vaccination. A more realistic approach undoubtedly would have avoided much of the undermining of public confidence which has occurred; instead however, the entire field of scientific investigation, depending largely upon public support, has suffered.

The reevaluation period recently announced seems an appropriate although belated decision. Sufficient time for consideration of the basic controls necessary for production, testing and implementation of the vaccine will probably allow solution of many of the

present problems. Following clear definition of the policies to be followed, resumption of the vaccination program can be expected to produce results which will once again allow the formalin treated vaccine to be regarded as safe, practical and effective.

The widespread concern over the safety of the formalin treated vaccine should not cause one to lose sight of the many unanswered questions in regard to vaccination against poliomyelitis. Moreover, many extremely important aspects of the pathogenesis and immunogenesis in poliomyelitis need extensive study. These large gaps in our knowledge will be filled only through the continued support of basic investigations.

Charles A. LeMaistre, M.D.

HAL M. DAVISON, M.D., IS PRESIDENT-ELECT



ON MAY 4, 1955, Hal McCluney Davison of Atlanta became president-elect of the Medical Association of Georgia for the year 1955-56, thus adding another accomplishment to the already long list of honors and offices held by him.

Dr. Davison is a graduate of Mercer University and the Atlanta Medical College (now Emory Uni-

versity School of Medicine), class of 1915. He interned at the New York Postgraduate Hospital where he later did postgraduate work in internal medicine. In 1928, he attended Cornell University for further study in the field of immunology. Dr. Davison was an associate in medicine at Emory University from 1923 through 1943, and associate medical attendant at Grady Memorial Hospital for the same period. He has been medical attendant at Georgia Baptist Hospital since 1923, and chief of medicine there since 1943. He is consultant in medicine for the Thomas-ton (Georgia) Hospital and Tanner Memorial Hos-pital (Carrollton, Georgia), and he has been con-nected with the Department of Medicine and Surgery, Veterans Administration, since 1946.

A first lieutenant with the U. S. Army Medical Corps during World War I, Dr. Davison served as assistant chief of medical service at the evacuation hospital in Siberia. During 1919-20, with the rank of major, he served as deputy commander directing civilian relief for the American Red Cross in Russia. While there, he met and married—on March 31, 1920, Miss Natalia Alexievna Beklemisheva. They have two sons, Peter and Alexis, and now live at 2888 Habersham Road, N.W., Atlanta.

Dr. Davison is a diplomate of the American Board of Internal Medicine and the American Board of Allergy. He is a fellow of the American College of Physicians, American College of Allergists (regent—1942, president—1948), and the American Academy of Allergy. He is a member of the American Heart Association, American Therapeutic Society (presi-dent—1949), Fulton County Medical Society (trus-tee—1947-52, president—1951), Southeastern Al-lergy Association (president—1946-47), Associa-tion for Study of Internal Secretions, Fifth District Medical Society (president—1935), Southern Medi-cal Association, International Correspondence Club of Allergy, Academy of International Medicine and Dentistry (trustee—1948, president—1949), Amer-ican Academy of Applied Nutrition (trustee—1948), and the International Association of Allergologists.

Dr. Davison has many interests other than medi-cal. He is a former president of the General Se-curities Corporation, 1947-48; president and medical director of the General Life Insurance Company; owner of the Parkaire Field Airport; and a member of the Board of Trustees of Mercer University. He is a member of the Atlanta Art Association, the American Legion, the Military Order of World Wars, Georgia Academy of Social Sciences, the Atlanta Civic Theater Group, Theta Kappa Psi, the Masons and the Shrinc. Dr. Davison is a Baptist and a mem-ber of the Piedmont Driving Club, the Atlanta Music Club, and the Gyro Club.

THE THERAPY OF SYSTEMIC MYCOSES

THE MEDICAL PROFESSION is becoming increasingly aware of the occurrence and importance of the systemic mycoses. Noteworthy progress has been made in recent years, leading to a far better understanding of these dangerous diseases from the clinical, diagnostic, and epidemiological points of view. A few of these infections, notably histoplasmosis and coccidioidomycosis, have even assumed major public health importance. It may be of interest to note that over 20 patients suffering from systemic mycoses have been diagnosed in Atlanta hospitals during the past few years, and the infections included cases of actinomycosis, cryptococcosis, blastomycosis, mucormycosis, and histoplasmosis. Specific therapy of these diseases, however, has lagged far behind the brilliant advances which have been made in the treatment of the bacterial infections; indeed, the use of some of the broad spectrum antibiotics has in some instances favored the emergence of troublesome candidiasis. That the field of antifungal therapy has come to life, however, is attested to by the ever-mounting number of drugs and antibiotic agents which are being developed and tested. There are such agents as ethyl vanillate which holds out promise in some cases of histoplasmosis. Other compounds, such as actidione, nystatin, and candicidin, are being extensively studied. Unfortunately, some of these are dangerously toxic, others hold out promise from laboratory studies which are not supported by subsequent clinical experience. The physician must also be wary of the early enthusiastic clinical testimonials. Better understanding of the clinical course of such diseases as histoplasmosis has changed the point of view that they are inevitably fatal, and it is now recognized that even disseminated

disease may in some instances regress and even heal under symptomatic therapy. Thus early successes are often followed by disappointment upon further experience.

However, it is worth emphasizing that some significant progress has been achieved, and that the physician of today has at his disposal more than potassium iodide for cervico-facial actinomycosis and for sporotrichosis. Thus, the prognosis of systemic actinomycosis and of aerobic nocardiosis has been very materially improved, since the sulfonamides, penicillin, streptomycin, and the broad spectrum antibiotics have all shown merit, and cures have followed the use of these agents alone and in combination where a hopeless outcome may have been otherwise anticipated. The therapeutic regimen, however, must be guided by the *in vitro* sensitivity of the organisms, since considerable strain differences in susceptibility have been reported. The need for prolonged therapy and the maintenance of high dosages must also be stressed. Ranking with the advances in the therapy of actinomycosis and of nocardiosis is the recognition that the diamidines are of great value in the treatment of North American blastomycosis. Following Elson's laboratory studies, Schoenbach, Greenspan and Snapper first established the clinical effectiveness of stilbamidine, while more recently hydroxystilbamidine has been developed to avoid the vexing neuralgias which may complicate the use of stilbamidine. One should not overlook the fact, furthermore, that whenever an isolated pulmonary focus has developed, as in pulmonary cryptococcosis, advances in thoracic surgery now make it possible to offer surgical extirpation, and that in other situations as well, surgery may be necessary to supplement the medical regimen.

One may confidently predict that the coming years will see continued significant developments in the specific therapy of the systemic mycoses. The practicing physician, therefore, must become increasingly familiar with these dangerous infections to assure prompt diagnosis and effective therapy.

Morris Tager, M.D.

"Professional Films"

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doctor placement page

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AVAILABLE PHYSICIANS

Buckner, Leslie, M., M.D., 937 Carew Tower, Cincinnati 2, Ohio—Age 54; married; Methodist; graduate University of Louisville, 1927; residency Bethesda Hospital, Cincinnati, Ohio; Association in Ob-Gyn with FACS; inactive reserve; has a Georgia license and could be available within 2-3 months.

Bryant, Milton F., Jr., M.D., 8166 USA Hospital, APO 547, San Francisco, California—Age 29; married; Protestant; graduate University of Michigan, 1948; residency University of Michigan Hospital; certified by American Board of Surgery; in service at present; specialty general surgery; available August 1955.

Clark, James H., M.D., Butler, Alabama—Age 32; married; Baptist; graduate University of Tennessee, 1946; recently in practice; desires location with better hospital facilities; interested in general practice.

Collins, Douglas, M.D., 172 Riverside Park, Iowa City, Iowa—Age 33; married; Methodist; graduate University of Alabama School of Medicine, 1951; residency State University of Iowa Hospital; specialty Ob-Gyn; available July 1, 1955.

Ferguson, Emmett, Jr., M.D., Duval Medical Center, Jacksonville, Florida—Age 34; married; Baptist; graduate Medical College of Georgia, 1950; 4 years general surgery residency; reserves; interested in general surgery; size of community preferred, 25,000 up; prefers partnership or single practice; available August 1, 1955.

Fletcher, William E., M.D., 3534 Stanford Place, Dayton 6, Ohio—Age 30; married; Protestant; graduate Western Reserve University, 1949; residency Cleveland City Hospital and VA Hospital; 3 years formal training general surgery; 2 year preceptorship general surgery; interested in general surgery in clinic or as an assistant or associate; available July 1956.

German, Walter A., Jr., M.D., 1934 Shoup Court, Apt. 2, Decatur, Georgia—Age 30; married; Methodist; graduate Washington University School of Medicine, 1951; residency Grady Memorial Hospital; specialty ob-gyn; desires associateship; available July 1, 1955.

Gillikin, Wm. Vernon, M.D., Columbus City Hospital, Columbus, Georgia—Age 30; married; Baptist; graduate Bowman Gray School of Medicine, 1954; interested in general practice in clinic; available July 1955; interned at present and interested in ob-gyn but if could find something interesting would consider general practice.

Gorman, John B., M.D., Capt. USAF (MC) AME, 6110th USAF Hospital, APO 1054, San Francisco, California—Particularly interested in general practice with some surgery or possible industrial medicine; graduate University of Virginia, 1951; rotating internship Charity Hospital 1951-52; practiced in Arizona less than a year before entering Air Force; licensed to practice in Virginia; served during past year as chief of Otolaryngology, and Chief of Aviation Medicine at General Hospital, Nagoya, Japan.

Hanberry, Richard L., Jr., M.D., 177 First Avenue, S. E., Atlanta, Georgia—Age 32; married; Episcopalian; graduate Medical College of Georgia, 1951; residency Grady Memorial Hospital, Atlanta; specialty Ob-Gyn; available August 1, 1955.

Hardegree, Harvey C., Jr., M.D., 26 Valley Road, Apt. 7, Drexel Hill, Pennsylvania; Age 34; married; Protestant; graduate University of Oklahoma, 1950; Board eligible general surgery; interested in general surgery in clinic, industrial; available July 15, 1955.

Howard, Hugh David., M.D., 1206 Roosevelt Road, Broadway, Illinois—Age 33; married; Protestant; graduate Northwestern University, 1947; residency VA Hospital, Hines, Illinois; completed three year approved residency in medicine; now Board eligible; presently in practice with VA, would like to go into private practice; Priority IV; specialty internal medicine; prefers clinic, or as assistant or associate; available anytime.

Jerius, Diab H., M.D., 18218 Appline Street, Detroit, Michigan—Age 51; single; Protestant; graduate Lausanne University; Switzerland, 1935; residency Sinai Hospital, Detroit; interested in general practice in Georgia as an associate; available immediately.

Johnson, B. T., Jr., M.D., 202 South 3rd Street, McGehee, Arkansas—Age 32; married; Baptist; graduate Arkansas Medical School, 1951; presently in practice, desires to relocate; interested in general practice in Georgia in clinic or as an assistant or associate; available immediately.

Johnson, Richard Chadwick, M.D., P. O. Box 304, Sand Springs, Oklahoma—Age 34; married; Presbyterian; graduate Yale University, 1945; residency Hillcrest Memorial Hospital, Tulsa, Oklahoma, one year surgery—University of Virginia Hospital, Charlottesville, Virginia, one year medicine—eight months residency credit in medicine USN; six years practice of internal medicine; presently in practice, would like a larger community not predominantly industrial and one that has more cultural advantages for family; Priority IV; specialty internal medicine; available in about 60 days following notice; will not accept any "practices for sale."

McConnell, Ben H., M.D., Box 664, Beltsville, Maryland—Age 36; married; Episcopal; graduate Georgetown University, 1950; interested in general practice as student health physician with any school, college or university; available at once.

Marder, Leon, M.D., 323 East Chestnut Street, Louisville 2, Kentucky—Age 32; married; Hebrew; graduate University of Oklahoma, 1949; USAF reserve; residency St. Johns General and Michael Reese Hospitals; specialty internal medicine; wishes to associate or share office space with another physician or enter private practice in a community where vacancies exist; available July 1, 1955.

Matousek, Wm. Chas., M.D., 9766 TU, Camp Detrick, Maryland—Age 31; married; Protestant; graduate University of Illinois, 1948; residency Walter Reed Army Hospital; passed Part I of the American Board of Internal Medicine; take Part II in May; available July 1955.

Mohr, Alton J., M.D., Tremonton, Utah—Age 40; desires rural area where one may raise a family in pleasant surroundings; preferably near a hospital; served in Army during World War II; been practicing in Utah since 1945; graduate Northwestern University; 10 years as a general practitioner; available immediately.

Patterson, James L., M.D., 412 National Bank Building, Logan, West Virginia—Age 55; married; Presbyterian; graduate Medical College of Virginia, 1928; residency C & O Hospital, Huntington, West Virginia; presently in practice, would like climatic change; interested in industrial medicine in Georgia.

Peake, Charles O., M.D., 884½ 9th Avenue S.E., Rochester, Minnesota—Age 27; married; graduate University of Pennsylvania 1951; internship Evanston Hospital; residency Mayo Foundation; Priority IV; specialty ob-gyn; prefers community of 50,000 or over; interested in locating in Georgia, particularly Atlanta, in clinic, as assistant or associate; available July 1, 1955.

Podgorski, Chester T., M.D., 3926 N. Kesler Avenue, Chicago, Illinois—Age 36; married; Catholic; graduate Medical School of Loyola, 1943; residency St. Mary of Nazareth Hospital, Chicago; 3 year approved residency in general surgery; desires to establish practice upon release from USN; interested in general surgery, individual practice; prefers Georgia; available immediately.

Qualls, Gene Thomas, M.D., Children's Hospital of Philadelphia, 1740 Bainbridge Street, Philadelphia 56, Pennsylvania—Age 30; married; Christian; graduate Vanderbilt School of Medicine, 1952; 2 years training in Pediatrics; specialty pediatrics; desires to associate with another pediatrician; desires practice in Georgia; available July 1955.

Richardson, B. A., M.D., 544 West 2nd Street, Lexington, Kentucky—Age 28; married; Methodist; graduate University of Tennessee, 1954; interested in general practice in Georgia; available August 1, 1955.

Rolfes, Harry Franklin, M.D., 1104 N. Shadeview Terrace, Birmingham 9, Alabama—Age 35; married; Catholic; graduate University of Maryland, 1944; has been in resident training, now wishes to locate for first time in ophthalmology; Category IV; prefers clinic; available July 1955.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland—Age 30; married; Roman Catholic; graduate Georgetown University 1948; residency USN Hospital, Bethesda, Maryland; Priority IV; specialty internal medicine; prefers community in Georgia of 20,000 to 30,000; available June 1955.

Sharp, Thomas B., Jr., M.D., 1530 Shoup Court, Decatur, Georgia—Age 28; married; Protestant; graduate Emory University, 1950; residency Lawson VA Hospital; Grady Memorial Hospital; military requirements fulfilled; specialty internal medicine; clinic preferred; available July 1, 1955.

Watson, Alfred Lawrence, M.D., 1415 Titus Road, Memphis 11, Tennessee—Age 29; married; Methodist; graduate Vanderbilt University School of Medicine, 1949; residency Grady Hospital and Kennedy

V.A. Hospital, Tennessee; Priority IV; specialty internal medicine; available July 1, 1955.

Wilson, James Woodfin, Jr., M.D., Essex County Sanatorium, Verona, New Jersey—Age 32; married; graduate Louisiana State University, 1948; residency Confederate Memorial Medical Center (internal medicine) one year; Essex County Sanatorium (pulmonary disease, at present); Priority IV; interested in general practice in clinic with emphasis on internal medicine, as assistant or associate or industrial; available about July 1, 1955.

Wimberly, John A., M.D., 909 North Broadway, Lexington, Kentucky—Age 29; married; Methodist; graduate University of Louisville, 1952; residency St. Joseph Hospital; will finish one year general surgery July 1, 1955; Priority IV; available July 1, 1955.

AVAILABLE LOCATIONS

Arlington, Georgia (Calhoun County)—Population 1,382. In need of doctor-surgeon for practice in new excellently equipped 16-bed hospital, located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia.

Broxton, Georgia (Coffee County)—Population 3,500—Doctors clinic available; also home available; 60 room county hospital at Douglas; seven room doctors building; no physician in area; physician will have more work than he can do. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia.

Dillard, Georgia (Rabun County)—Population 2,500. Doctor's office to be fur-

nished rent free for one year; would rent five or six room house, fully equipped kitchen, county hospital at Clayton; drug store, and pharmacist; good schools; doctor would be welcome right now; late doctor had an excellent practice; other benefits considered in a short time; active church groups and community club that would be happy to assist doctor. Contact: Mrs. L. Neville, Dillard, Georgia.

Edison, Georgia (Calhoun County)—Population 1,245. Two physicians in area; Hill-Burton Hospital (1 mi.); one clinic local with 10 beds, x-ray, lab equipment, operating room with instruments; rental \$75.00 (maximum \$100.00) per month; two excellent drug stores; housing available for rent at \$30-\$40; good elementary and high schools; five churches; great need for a physician in this community. Contact: Dr. J. S. Beard, Edison, Georgia.

Hampton, Georgia (Henry County)—Population 1,000—No doctor in Hampton, nearest 10 miles away; hospital in Griffin; office space, housing available; contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia.

Marietta, Georgia (Cobb County)—Population 10,000. Interested in Negro physician to replace present physician who is going into Armed Forces in approximately six months. Contact: Mr. M. L. Wear, Administrator, Kennestone Hospital, Marietta, Georgia.

Smithville, Georgia (Lee County)—Population 700—No physician in area; home in Leesburg, office downtown rent free; completely equipped office of two rooms and connecting lavatory with outlets for sterilizers, etc., attached. All private practice available. Contact: Mr.

Charles A. Dean, Smithville Drug Store, Smithville, Georgia.

Tifton, Georgia (Tift County)—Population 12,000—Local hospital available; housing available at reasonable cost; especially need EENT man. Contact Mrs. Agnew Andrews, Tifton, Georgia.

Unadilla, Georgia (Dooly County)—Population 1,200—Dooly County Hospital owned and operated by the people of the county; office space available or will build small clinic and let doctor rent or buy. Housing will be provided rent reasonable or can get house built to suit. They guarantee a good doctor will do well; one physician in area, age 75. Contact: Mr. E. H. Conner, Unadilla, Georgia.

Winder, Georgia (Barrow County)—Population 6,000. Eight physicians in area; four active, two part time and two inactive; 40 bed Hill-Burton Hospital in city limits—completely equipped; office space available; three active drug stores; interested in obtaining services of two or three young physicians who want to do general practice; feel that area has much to offer with a good sound economy, ideal location, adequate hospital facilities and a crying need for well trained interested men; contact, by phone, mail or in person for any further information, Dr. C. E. Skelton, Peoples Bank Bldg., Winder. (Office Phone 3851).

Woodbine, Georgia (Camden County)—Population 1,000. Small, fully equipped office and clinic available; ample office space, delivery room, laboratory (inc. x-ray), nursery, wards, private rooms; five room wooden dwelling adjoins hospital available at \$35.00 mo.; one other doctor in Woodbine, doctor is needed now. Contact: Dr. S. C. Atkinson, Waverley, Ga.

please notify . . .

Medical Association of Georgia 875 West Peachtree Street, N. W. Atlanta, Georgia

. . . when a location has been filled

Navy Offers Commissions to Med Students

IN ITS ENDEAVOR TO MAINTAIN the finest medical and dental corps in the world, the United States Navy has announced a policy whereby medical and dental students can become commissioned officers while still in school.

In order for the Navy to insure that it will have qualified doctors and dentists and not have to rely upon selective service as a means of obtaining their medical and dental corps officers, probationary commissions are now being given to students, who qualify, while they are attending school.

Any person, male or female, who is attending an approved medical or dental school can apply for a commission in the Navy provided he is between the ages of 19 and 30 and is found to be mentally, morally, and physically sound.

Those individuals who meet all of the Navy's qualifications will be appointed *ensign* in the Inactive Naval Reserve and will not have to attend Naval Reserve meetings or participate in summer cruises, but may do so if they wish. All persons accepted in this Navy program will be legally deferred from the draft so long as they remain in school. When their professional education is completed (and upon completion of 12 months internship in the case of medical students) they will be commissioned lieutenants (junior grade) in the Medical Corps or Dental Corps of the Navy and will be called to immediate active duty, being stationed at one of the Navy's many medical or dental activities.

Detailed information concerning this program can be obtained by writing the Office of Naval Officer Procurement in Macon, Georgia.



BOOKS RECEIVED

Conn, Howard F., M.D., (Editor), *Current Therapy 1955, Latest Approved Methods of Treatment for the Practicing Physician*, W. B. Saunders Company, Philadelphia, 1955, 692 pp., \$11.00.

Fulton, John F., M.D. (Editor), *A Textbook of Physiology, Seventeenth Edition*, W. B. Saunders Company, Philadelphia, 1955, 1,275 pp., \$13.50.

Ochsner, Alton, M.D., F. A. C. S., and DeBakey, Michael E., M.D., F. A. C. S., (Editors) *Christopher's Minor Surgery, Seventh Edition*, W. B. Saunders Company, Philadelphia, 1955, 547 pp., \$9.00.

Martin, Gustav J., Sc. D., *Ion Exchange and Absorption Agents in Medicine, The Concept of Intestinal Bionomics*, Little, Brown and Company, Boston, 1955, 333 pp., 36 illustrations, \$7.50.

Alexander, Harry H., M. D., *Reactions with Drug Therapy*, W. B. Saunders Company, Philadelphia, 1955, 301 pp.

Early Care of Acute Soft Tissue Injuries, American College of Surgeons, 1954, 192 pp., \$1.00.

An Outline of the Treatment of Fractures, American College of Surgeons, 1954, 93 pp., \$1.00.

Stanbury, John B., M.D.; Brownell, Gordon L., Ph.D.; Riggs, Douglas S., M.D.; Perinetti, Hector, M.D.; Itoiz, Juan, Ph.D., and del Castillo, Enrique B., M.D., *Endemic Goiter, An Adaptation of Man to Iodine Deficiency*, Harvard University Press, Cambridge, 1954, 206 pp., \$4.00.

Al Akl, F. M., M.D., *Surgical Technigrams*, McGraw-Hill Book Co., New York, 1954, 346 pp., \$12.00.

Deutschberger, Otto, M.D., *Fluoroscopy in Diagnostic Roentgenology*, W. B. Saunders Company, Philadelphia, 1955, 771 pp., 888 illustrations, \$22.00.

Allen, Edgar V., M.D.; Barker, Nelson W., M.D.; and Hines, Edgar A. Jr., M.D., *Peripheral Vascular Diseases*, W. B. Saunders Company, Philadelphia, 1955, 825 pp., 316 illustrations, \$13.00.

REVIEWS

Fish, John S., M.D., F.A.C.S., *Hemorrhage of Late Pregnancy*, Charles C. Thomas, Springfield, Ill., 1955, 180 pp., \$5.50.

In this book: *Hemorrhage of Late Pregnancy*, we have a well written monograph on a very important topic by a comparatively new author. There are eight chapters, 180 pages with several clear cuts and illustrations, and an excellent bibliography. The author generously gives equal credit to his group associates for the material and for the observations and conclusions reached. The book is dedicated to the

senior member of the group, Dr. R. A. Bartholomew, whose keen analyses and clinical records have been meticulously kept since 1918. And while not so stated, indeed it is believed by many that he has probably personally examined more placentae than any man of our time. It is not unlikely that his work and observations have been the inspiration and stimulating factor to the author in the preparation of this book.

Much space has been taken, and properly so, with discussion of the three most commonly considered causes of bleeding in the last trimester. Namely: (1) Abruptio Placentae; (2) Placenta previa and (3) Rupture of the marginal sinus. However, other important but less frequent causes of hemorrhage are recognized and duly mentioned. Detailed discussions of the basic etiological factors concerned in each of these three, along with symptoms and a critical discussion of the clinical features, are given. Many details not ordinarily listed in text books are noted, indicative of a close observation over a long period of years and also of a wide clinical experience. Much space is given to the anatomy of the placenta—valuable as a forerunner to the pathological discussions to follow.

Perhaps the outstanding and most enduring part of the monograph is the emphasis brought to the reader's attention upon the part played by rupture of the marginal sinus. As very ably pointed out, this entity was described some 60 years ago, yet text books and writers have consistently ignored or passed it up with little comment. The author has rightly centered our attention on this much neglected phase of bleeding in late pregnancy, not only in this treatise but in other previously published articles.

Another interesting observation made is that the bleeding in placenta previa is often due to rupture of the marginal sinus—even as is the case where the placenta is normally situated. Obviously no one can deny this possibility. He does not, however, discount the older concept of bleeding in placenta previa as being due fundamentally to the changes incidental to uterine contractions—development of a lower uterine segment and possibility in some cases to effacement of the cervix and those changes involving “area relationships.” Most clinicians will agree with this practical viewpoint.

The modern conservative attitude in the management of both placenta previa and abruptio placentae is again brought to the reader's attention and emphasized. Also hope is expressed that newer and

more efficient means of preventing prematurity along with gratitude to pediatrics and other sciences for a higher salvage rate of the premature babies.

This book should be valuable to all interested in the practice of obstetrics—whether teacher, student, specialist or general practitioner. As pointed out by many studies of maternal mortality, hemorrhage still stands out as one of the three greatest causes of loss of mothers. And in view of the fact that the mortality rate has not been lowered in this group of cases to the same extent as it has in the infections and toxemias, this book is particularly timely.

One suggestion to make. Throughout the book some of the sentences seem unusually lengthy—50, 60 or 80 words in some. It would make for easier reading to have short sentences with fewer qualifying and conditional clauses.

A clear statement of the author's concept of just what takes place in the majority of instances of bleeding at this time is well expressed in the last sentence of the last chapter, which we quote: "There would seem to be little room for doubt that, for most practical purposes, regardless of the position of the placenta, the major painless hemorrhages of late pregnancy have the same cause, the same mechanism, the same source of bleeding, to a large extent the same clinical and pathologic findings and the same general and basic principles of treatment except for the use of cesarean section in certain varieties of low placental implantation."

Charles B. Upshaw, M.D.

MacLachlan, John M., Ph.D., *Planning Florida's Health Leadership: Florida's Hospitals and Nurses*, University of Florida Press, Gainesville, 1954, 122 pp., \$1.50.

Volume IV of the series of publications stemming from the University of Florida's study of the health requirements of the state is devoted to the need for hospital beds and nurses. This section of the study sets forth facts of importance to the state and the university and would be useful to any state or region. The data reflect the number of hospital beds currently available and the estimated future need in light of a complex of pertinent factors. As an example, per diem costs of hospitalization are considered in relationship to medical education and research and the availability of insurance coverage. Geography, climate, highways, and population distribution, as well as the age of citizens of the state and the ratio of beds to populations, are factors influencing the study. The ratio of the present number of beds available to the population is compared with the ideal ratio. Florida now has 2.98 short-term hospital beds per 1,000 population; the ideal is considered generally to be 4.5 beds per 1,000. It is pointed out that the population of the state has increased by 19 per cent between the years 1950 and 1953.

In planning the health care of the people of Florida, the percentage of occupancy of hospital beds is listed in tabular form. The point is made that in certain regions of the United States, where there is the ideal ratio of beds to population, there has been no decline in the occupancy rate of general hospitals offering short-term care for acute illness. The national rate of occupancy of general hospital beds is 73.3 per cent. In certain areas of Florida this rate is as low as 63.5 per cent, which rate probably is influenced by the seasonal fluctuation of population density.

The numbers of nurses in all categories now available are listed in the form of tables, by cities and counties as well as by total figures. Estimated present needs and future needs are described. Facilities for training professional nurses in the college program, registered nurses from the hospital program, and practical nurses are thoroughly explored. The median age for all categories of nurses in Florida is 35 years. The peaks of age distribution to nursing activity fall within the younger and the older age groups. This apparently is due to the fact that nurses drop out of the profession when they marry and return to it after their children have grown to high school age or beyond. Of interest to all is a study in 1951, reported by the American Nurses Association, which shows that 60.1 per cent of graduate nurses in the United States are working in their profession and that 57.9 per cent of the nurses in Florida are active.

This report presents another aspect of Florida's needs and plans in the health fields, but they also may derive useful information in considering health plans for other states and regions.

R. Hugh Wood, M.D.

Kisch, Bruno, M.D., Glover, Robert P., M.D., and Graybiel, Ashton, M.D., (Editors), *Transactions of the American College of Cardiology, Volume III, 1953*, The American College of Cardiology, New York, 1954, 259 pp.

The volume consists of 38 short papers presented at the meetings of the American College of Cardiology in June 1953 and November 1953. Some of the material is interesting, but since none of the papers are published elsewhere, they would seem to be lost in a publication of this sort. In general, the subjects are routine and most presentations are too short. As an example, the incidence of congenital heart disease is covered in four pages. The illustrations are excellent. Included in the volume is a "Chronological Outline of the Development of Diagnostics in Cardiology" which has several references to the contributions of the founders of the American College of Cardiology.

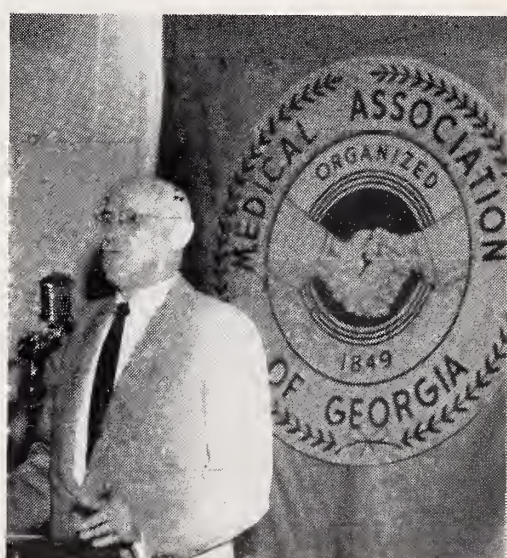
I doubt if there is a distinct need for the publication of this volume. A few of the papers should be included in more widely distributed journals.

Thomas L. Ross, Jr., M.D.



Highlights of the Annual Session

First Prize Scientific Exhibit, "Anatomy of Bronchoscopy," presented by the Department of Surgery of Emory University School of Medicine at Grady Memorial Hospital, Atlanta, with one of the exhibitors, William D. Logan, and Miss Carolyn Roper.

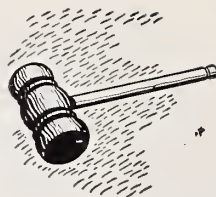


Left—C. M. Templeton, Richmond County Medical Society President, Milford B. Hatcher, and Elmer Hess; Center—Clarence L. Ayers, Toccoa, General Practitioner of the Year; and Right—Elmer Hess, President-Elect of the American Medical Association.



Left—Peter B. Wright, Mrs. Goodwin, Thomas W. Goodwin, Mrs. Allen, H. Dawson Allen, Jr., at the President's Dinner; Right—Panel on "Radioactive Isotopes in Medicine;" pictured are Fred H. Simonton, Richard H. Chamberlain, B. Shannon Gallaher, Gould Andrews, and Stephen W. Brown.

president's page



On assuming the presidency of the Medical Association of Georgia, aggravated by considerable timidity, my emotions are quite scrambled. I am naturally exceedingly proud of this honor and confidence given me by a vote of the membership. However, I feel completely subdued with humility in previewing my responsibilities. I cannot claim any conscious feeling of leadership; in fact, in matters of controversy I most often find myself a meek and speechless member of the minority. Life has been too easy for me to ever develop a crusading spirit or great zeal for a cause. I take for granted that all doctors of medicine who are duly licensed to practice and are dues paying members of their respective county societies, and on up, are men of conscience. That success is based on services rendered and not material gains.

Training and supervised experience must prepare one for service. Somewhat of a pity, for the sake of wives and children, we have to be professional and make charges where charges are possible. This reasoning leads out on a limb without duty but also excludes fear of competition other than from those better trained. Competition from a proper type of training should always be welcomed as a challenge to experience.

My mixed emotions also produce some concerns, that I hope will disappear with my tenure of office. If not, I will drop a few suggestions for the sake of argument in my next eleven pages, if these meet the deadline and get by the Editorial Board. I am also looking to the Board for protection from aberrations and complete untimeliness.

H. D. Allen, Jr.



H. Dawson Allen, Jr.
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3—M. F. Arnold, Hawkinsville 8—Hubert Milford, Hartwell
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Rural Health Committee Meeting

Macon, March 13, 1955

The meeting of the Rural Health Committee of the Medical Association of Georgia was called to order at 10:30 a. m. After a brief invocation, the business was outlined.

Since all members of the committee had received copies of both the minutes of the last meeting of the full committee and those of the meeting of the "steering committee," reading of the minutes was omitted.

Chairman Nicholson asked Charles T. Brown, Guyton, to review and comment on the status of the Physician Placement Service of the Association. Dr. Brown stated that he had contacted Mrs. W. Bruce Schaefer, President of the Better Health Council of Georgia, and that she had agreed to her organization's investigating any communities requesting a physician in which there might be controversy, and rendering a report of a lay committee to the Rural Health Committee. This organization has begun to function, and at this meeting the first report was submitted to the committee.

Dr. Brown then advanced the suggestion that the Rural Health Committee should go beyond just advertising the available locations and should actively educate the public on a method of obtaining a doctor for their community. He felt that the committee should draw up a brochure incorporating in it those requirements that a community should be able to meet when requesting a physician and those things which would encourage a young general practitioner to come to their community. To be included in this brochure would be a score sheet on which the community would "score" itself and return it to the Rural Health Committee. This would help both the town and the committee. This was unanimously adopted, and Dr. Brown was instructed by the chairman to draw up the first outline of the brochure and questionnaire and to present this to the next meeting of the committee.

R. C. Williams, State Health Department, Division of Hospital Services, assured Dr. Brown that his department would gladly make available its results of investigation of towns requesting physicians in which they had made an investigation.

T. A. Sappington, Thomaston, reported on those towns or communities in the Fourth District requesting physicians, and they were either approved or referred to the Better Health Council. Hubert Milford, Hartwell, then reported on the communities in the Tenth District, and a similar disposition was made. Maurice F. Arnold, Hawkinsville, reported on the situation in the Third District. W. A. Dodd, Wrightsville, reported on those towns in the Sixth District. It might be noted that with the exception of the Fifth District a complete report was made on all the communities in the State requesting the services of a physician.

W. P. Stoner, Sylvester, in charge of Home and Farm Safety, then made a report on his investigations.

Home and Farm Accident Prevention Report

The incidence of accidental injury and death is increasing on the farms in Georgia. Some reasons for this increase are: the expanding use of machinery. In 1940 there were 9,327 tractors

in use on Georgia's farms. The 1955 estimated number is 95,000 farm tractors in the State. Other farm machinery has increased. There is a wider use of poisonous insecticides and more farm ponds and lakes have been built.

Accidental death from all causes ranked fourth among the causes of death in Georgia in 1952. Home accidents ranked seventh as a cause of death the same year. Fire and falls are two major causes of death in the home, while machinery leads as the cause of accidental death in the farm occupational group. During the 1950-52 period Georgia had 239 fatal farm accidents; 61 of these were due to farm machinery.

Of the 15,000 workers killed on the job in 1953 from all causes over the nation, 3,800 were killed in farm work. There were 320,000 non-fatal farm injuries during the same period. Fatal farm injuries ranked third nation-wide, led only by mining and construction industries.

These injuries and deaths have resulted in considerable loss of time and money, extended hospitalization, suffering of the victims and misery and heartaches for the survivors.

As physicians, we play a leading role in these dramas of life and death and as thinking, responsible citizens, we should show our interests in preventing these accidents.

Industry long ago learned the value of accident prevention. Most industrial companies have safety programs with full-time employees who devote all their energies toward the prevention of accidents in their groups. During the past 40 years these safety practices in industries have lowered the accident rate 80 per cent.

Industry pays an average of \$10.00 per employee per year for their safety program. This costs industry over the nation almost \$400,000,000.00 annually. This cost is willingly assumed by the industries so it must be, in their opinion, a good investment.

There are 198,191 farms in Georgia with an average value of \$5,336.00, representing an investment of \$1,057,547,176.00. This does not include the cost of tractors and other equipment. There are 263,313 permanent workers on these farms not including seasonal workers. An organization of this magnitude, with such a large investment and representing such a large number of people, surely deserves a safety program.

Present work being done in this line of endeavor includes the safety programs sponsored by various organizations. The Georgia Department of Public Health has a home safety unit, financed by the grant of the Kellogg Foundation that allows them to operate for a limited time. This unit has collected much statistical data. This data will, of course, be very valuable for use in the organization of any safety program. It has been in existence for about a year. The 4-H Clubs have a project in farm safety that many of their members take during their training. The National Safety Council has a farm division which publishes a bi-monthly brochure the Farm Safety Review, issues leaflets, films, posters and numerous other information and helpful aides to promote safety on the farm.

A Rural Safety Organization in the State is needed to bring this available information to the man on the farm.

The Agricultural Extension Service in Athens plans a Farm Safety Council for the purpose of studying and combatting accidents that occur on the farm. An organizational meeting will be held sometime in April.

Thirty-four states have already established Farm Safety Councils. Available figures in five of these states show various decreases in accident rates over a three to 17 year period of 20 per cent to 75 per cent. Such decreases in rate are worth working for in our State.

A Farm Safety Council could consist of a State agency and county organizations. The State council would gather information and statistics from over the State, advise and give out safety educational information and give aide and counsel to the county organizations. Each county could have a safety council whose services could be voluntary. These councils would investigate each serious accident and advise how it might have been avoided and carry on educational activities.

As to expense, many of the states finance their organizations through funds, from the Extension Service with the aide of voluntary contributions. Some have only one full-time safety specialist. Others get along on simpler procedures.

Our original purpose in this study was to investigate the possibility of organizing a Farm Safety Council in Georgia. After investigation, I am delighted to find that plans are already in progress for the organization of such a council by the State Agricultural Extension Service.

I am of the opinion that we of the Rural Health Committee of the Medical Association of Georgia should aid and support this organizational movement for a Farm Safety Council in

Georgia and give it our continued support.

Respectfully submitted,

W. P. STONER, Member in Charge
Farm and Home Safety

M. F. Arnold then reported in his investigations into the formation of a Standard Program of Immunization. This is to be established on the present information recommendations and then be revised from time to time as changes take place. Dr. Arnold recommended that this short program standard immunization should be given to the senior medical students, internes and residents under the sponsorship of the Medical Association of Georgia; further that a letter should be sent to the secretaries of the county societies to be read at regular meetings of the society, and further that from time to time a card should be sent out reminding the general practitioner and pediatrician of the standard program and any revisions which may have taken place.

The program was unanimously adopted, and Dr. Arnold was instructed to draw up a short, concise form to be submitted by the chairman to the Public Health Committee for its approval and that of the Committee on Maternal and Infant Welfare of the MAG.

R. C. Williams, Division of Hospital Services, State Department of Public Health, then spoke to the committee on the facilities available in Georgia for the physician practicing in rural areas. He distributed two booklets, "Hospital Construction Program in Georgia 1947 to 1954", and "Hospital Progress Report and the Medical Facilities Act of 1954." He then discussed these booklets and their statistical contents and answered questions of members of the Committee. A most interesting comment by Dr. Williams was that 80 per cent of the hospitals in Georgia are 50 beds or less (240 hospitals in the state), which means that the patient-bed rate is much better in Georgia's rural areas than ever before.

Chairman Nicholson then reported on the two meetings of the American Medical Association Council on Rural Health, which were held since the last meeting of the committee. Dr. Nicholson stated that the Miami meeting was informative, but there was little time for discussion. The Tenth Annual Conference on Rural Health held in Milwaukee, Wisconsin, February 23 through February 26 had as its theme "Looking Both Ways"—the 10 years past and its accomplishments and a long look to the future. The outspoken comment of the lay-members of the conference was a demand for the immediate return of the family doctor, in contradistinction to the groups, mass production and production line medicine.

The meeting then adjourned for luncheon with the wives. After lunch, it was decided by the committee that, for the present, plans for a Georgia State Conference on Rural Health should be deferred until we could contact Rural Health Committees of other states which sponsor Rural Health Conferences and to obtain all the information possible as to organization, speakers, and program content.

Chairman Nicholson then proposed the plan that the Rural Health Committee could sponsor a "Senior Day Program" to be given to the senior medical students of both the Emory University School of Medicine and the Medical College of Georgia in the near future, more expressly during the present year. This program was to be organized by a committee composed of Chairman Nicholson, T. A. Sappington and Hubert Milford. They

are to formulate a program for a talk by two general practitioners and two wives of general practitioners, a social hour and a dinner for senior students and their wives or sweethearts. They are to contact the dean of each of the medical schools and make the necessary arrangements.

The committee then decided that its next meeting should be held at 10:00 a. m., Sunday, May 1, 1955, at the Bon Air Hotel in Augusta, preceding the first meeting of the House of Delegates.

The meeting was adjourned in good order at 2:45 p. m.

Those present were: Geo. T. Nicholson, Cornelia; W. P. Stoner, Sylvester; M. F. Arnold, Hawkinsville; W. A. Dodd, Wrightsville; Charles T. Brown, Guyton; T. A. Sappington, Thomaston; R. C. Williams, Atlanta; T. F. Sellers, Atlanta; and J. Hubert Milford, Hartwell.

Maternal and Infant Welfare Committee Meeting

College Park, March 20, 1955

Chairman Hydrick called the meeting to order at 1 p. m. Members of the Committee present were: Helen W. Bellhouse, Atlanta; Fred H. Simonton, Chickamauga; George H. Alexander, Forsyth; Thomas C. McPherson, Atlanta; Eugene Griffin, Atlanta. Also present were Mr. Krueger, Executive Secretary of the Medical Association of Georgia and Mr. Wells of the State Department of Health.

The minutes of the October 2 meeting of the Maternal and Infant Welfare Committee were approved as published in the January issue of the *Journal of the Medical Association of Georgia*.

First item in the order of business concerned an appointment to replace Howard J. Morrison, Savannah, who cannot serve on the committee for the year 1955-56 because of prior commitments. Dr. McPherson and Dr. Bellhouse were appointed to consider replacements for Dr. Morrison.

The next item of business concerned a paper on "Retrolental Fibroplasia." It was recommended that the paper, after certain revisions, be submitted to the *Journal of the Medical Association of Georgia* for publication. Dr. McPherson and Dr. Bellhouse, as a Committee on Revisions, were requested to send the paper to Edgar Woody, Editor of the *Journal*. It was also recommended that reprints of the paper as published in the *Journal* be sent to every hospital administrator in the name of the Committee on Maternal and Infant Welfare. It was also recommended that a copy of it be sent to Peter Hydrick, Editor of the Georgia Academy of General Practitioner's bulletin requesting his publication of the material.

Next item of business was a discussion of the scientific exhibit by the Committee on Maternal and Infant Welfare to be presented at the 1955 Annual Session in Augusta. A report on this was given by Dr. Bellhouse who has taken care of all the details of the exhibit.

The next item of business was presented by Chairman Hydrick. He read his annual report, as chairman of the committee, to the MAG House of Delegates. The report was approved with one correction, the

word, "multi disciplinarian" should be stricken from the last sentence of the report.

The next item of business was a review of the maternal death questionnaire as received by the committee concerning their investigation of maternal and infant deaths. Forty-one questionnaires have been received to date, and it was brought to the attention of the committee. It was then decided that six or eight questionnaires would be given to each obstetrician and GP for his review. A motion was made that a form be filled out by each member of the committee reviewing these questionnaires. The committee then set about making up the form to be used by committee members in this connection.

Item 1 on the form was to be Case Number; Item 2, Cause of Death as stated on death certificate; Item 3 was to include one sentence stating that these reviews were done in retrospect, were anonymous and based entirely on the data furnished from both the death certificate and questionnaire filled out by the doctor who attended the patient; Item 4, Cause of Death—review of above regardless of cause on death certificate; Item 5, Preventable or Non-preventable in the opinion of the reviewer; Item 6, Recommendations and Comment. It was also recommended that a terminology list be prepared by Mr. Wells, statistician for the State Department of Health to go along with the form and thus explain it to the physician filling out the form from the data. Discussion then ensued concerning infant deaths; it was decided that the same form be used but that a pediatric subcommittee of three members, headed by Dr. McPherson, review this form and present their recommendations at the next meeting of the Maternal and Infant Welfare Committee.

The next item of business concerned a report on midwifery by Dr. Bellhouse. Dr. Bellhouse asked for a member of the Association's Maternal and Infant Welfare Committee to advise the State Health Department

on midwife education in related matters. Dr. Mulherin was appointed in this capacity, and it was recommended that he be asked to counsel with Richard Torpin, Medical College of Georgia, Augusta, on this matter.

The next item of business concerned the appointment of Dr. Mulherin, Dr. McPherson and Dr. Hydrick to represent the Maternal and Infant Welfare Committee at an April 14 meeting on the subject, "How Can You and/or Your Organization Contribute Most Toward Meeting the Needs of Rural Obstetrics and Infant Care."

The next item of business concerned a trial run in the use of the newly devised form questionnaire to be used by Committee members in reviewing the cases. Certain recommendations were made during this trial run: (1) When a consultant was used in connection with the maternal or infant death that the consultant be requested to fill out the same questionnaire as the physician so that the committee might have more information available in reviewing the case. (2) It was recommended to add to the questionnaire sent the physician oxitoxic drug, amount, how given, time, before delivery of infant, after delivery of infant, before delivery of placenta, after delivery of placenta; also, labor stimulants, method, drug, how administered. Another addition for the physicians' questionnaire was to be the question, "Was Blood Available?" The addition of this material was to be worked out by Dr. Bellhouse in conjunction with Mr. Wells of the State Department of Health, and the new questionnaire to be sent the physician was to be presented at the next meeting of the committee. It was also recommended that Dr. McPherson work out additional questions for the questionnaire to be sent the physician for infant deaths.

A motion was made and unanimously passed that a letter of appreciation of the committee members be sent to Dr. and Mrs. Hydrick for their hospitality to the committee at this meeting.

There being no further business the meeting was adjourned at 5:15 p. m.

Special Information Requested!

A SPECIAL GRANT HAS been made to the Department of Pathology, Louisiana State University School of Medicine, to investigate the mechanism of action of anticholinesterase insecticides and the therapy of poisoning resulting from excessive exposure. The widespread use of Parathion and TEPP (tetraethyl pyrophosphate) in agriculture, industry and the home is causing an increased number of accidental exposures. Their interest encompasses clinical observations as well as studies on fatal cases at autopsy.

If a case of poisoning by any of the anticholines-

terase insecticides comes to your attention, it would be appreciated greatly if you would allow them to obtain information on the case. Because of the rarity of this condition and certain unusual aspects of therapy they are prepared, when requested, to give recommendations as to treatment in a surviving patient. They are also prepared to send an investigative team at their own expense. Telephone calls to report cases and request information will be accepted at any time, day or night, by Dr. Stanley H. Durlacher, New Orleans, Franklin 4141, collect.

Selection of Patients for Cardiovascular Surgery

JAMES L. ALEXANDER, M.D., Savannah, Ga.

ALL PHYSICIANS SHOULD have at least a passing acquaintance with the cardio-vascular lesions amenable to surgical therapy, so that they may advise their parents. Space limitations preclude anything approaching a complete discussion of these lesions, but the following outline may serve as a guide for the physician confronted with the more common conditions for which surgical therapy has a proven value.

Patent ductus arteriosus: The diagnosis is made by the presence of the typical machinery murmur heard in the second interspace to the left of the sternum. Usually little or no disability is present. The potentiality of endocarditis makes surgical correction mandatory. Excellent functional results may be anticipated. Surgery is best done between the ages of seven and 20 years.

Tetralogy of Fallot: This is the only congenital cardio-vascular lesion in which cyanosis is manifest in early childhood, which is associated with life expectancy beyond the first year. The value of the systemic-pulmonary artery shunt operations is well established. Surgery is best done between the ages of three and seven years but should not be withheld at any age if the patient shows signs of cardiac failure. The overall post-operative mortality rate of 10 to 15 per cent is far below the mortality of the untreated disease. Good functional results may be anticipated.

Pure Pulmonic Stenosis: In this malformation, right sided cardiac enlargement and extreme dyspnea, with cyanosis varying in degree from absent to marked, are present. The severity of the symptoms depends upon the degree of the stenosis. Surgical correction will give good functional results.

Coarctation of the Aorta: Hypertension of the upper extremities with hypotension of the lower extremities makes this diagnosis. Approximately 60 per cent of patients with coarctation succumb to cerebral or cardio-vascular complications before the age of 40. Surgery is safe and effective, the operative mortality, with increasing experience, now being no more than one per cent.

Mitral Stenosis: Most authorities are in agreement that for selected cases surgical therapy is the therapy of choice. Certainly not all patients who manifest the murmur should be operated upon. The consensus of conservative surgical and medical thought concerning such surgery may be summarized:

(1) Patients with only very mild disability and stable dynamics probably should not be operated upon. Should their disability progress, they become candidates for surgery.

(2) Patients with moderate to severe progressive disability with bouts of pulmonary edema and/or hemoptysis, who may have had episodes of auricular fibrillation or embolic phenomena and who may have had mild bouts of heart failure, easily controlled by digitalis, comprise the group for which surgery offers the best chance of recovery.

(3) The onset of exertional dyspnea and orthopnea indicate a myocardium taxed beyond its limit. The probabilities are that this condition will worsen, and that the expected life span may be months, rather than years. Even should survival be more than 12 to 18 months, the patient will be a cardiac invalid. In competent hands, mitral commissurotomy is preferable therapy for this group.

(4) Patients with intractable failure, already cardiac invalids, present a far less fertile field for surgical endeavor. However, in spite an operative mortality rate of 50 per cent and poorer functional results than in the previous group, these patients probably should be given the benefit of surgery. Without surgery, the outlook is hopeless, with death to be expected within six months, and surgery can salvage a number of these.

Much cardiac surgery is still in experimental stages, but for many lesions surgical therapy offers a mode of cure, or of improvement, not available a few years ago. Patients with these lesions are first seen by the practitioner whose recognition of these conditions and awareness that surgical therapy is available will save many from needless invalidism or death.

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.

ANNOUNCEMENTS

Boston Clinical Meeting, American Medical Association—November 29-December 2, 1955. All persons who desire a place on the lecture program at the meeting are urged to communicate immediately with the Chairman of the Program Committee, Theodore L. Badger, M.D., c/o Mass. Medical Society, 22 The Fenway, Boston 15, Mass. Applications for space in the Scientific Exhibit may be obtained from the Secretary, Council on Scientific Assembly, A.M.A., 535 North Dearborn Street, Chicago 10, Ill.

83rd Annual Meeting American Public Health Association—Kansas City, Mo., November 14-18, 1955. Theme of meeting is "where are we going in public health?" For further information write to Dr. Reginald M. Atwater, Executive Secretary, American Public Health Association, 1790 Broadway, New York, N. Y.

American College of Chest Physicians 21st Annual Meeting—June 1-5, 1955, Ambassador Hotel, Atlantic City, N. J. The scientific program will include approximately 200 speakers. Fellowship examinations will be held on June 2, and Fellowship certificates will be presented at the annual Convocation which will precede the Presidents' Banquet on June 4. All physicians are invited; there is no registration fee. For information write to the Executive Offices, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Illinois.

Eight Week Comprehensive Course in Industrial Medicine—beginning September 26, 1955, Post-Graduate Medical School of New York University-Bellevue Medical Center, New York City. Among the subjects offered are: organization, administration and economics of an industrial medical department; the practice of preventive and constructive medicine in industry; the clinical aspects of occupational diseases; industrial injuries and the elements of safety programs; and toxicology and industrial hygiene for the physician. Applications should be sent to the Dean, NYU Post-Graduate Medical School, New York 16, N. Y. Tuition \$250.00.

Southern Pediatric Seminar—July 11-30, 1955, Saluda, North Carolina. The course will be divided into three one-week sessions; the first two sessions will be devoted to pediatrics and internal medicine, the third week will be given over to obstetrics and gynecology. The seminar is accredited by the American Academy of General Practice for post-graduate instruction. For further information write to Dr. D. L. Smith, Registrar, 187 Oakland Ave., Spartanburg, S. C.

Short Course in the Clinical Pathology and Pathology of Parasitic Diseases—August 15-17, 1955, Louisiana State University School of Medicine, New Orleans, La. The fee for the course is \$50.00. For further information write to Dr. Clyde Swartzwelder, Dept. of Microbiology, L. S. U. School of Medicine, 1542 Tulane Ave., New Orleans 12, La.

DEATHS

EDGAR CASHION HOLMES, Moultrie, died on April 13, 1955, at the age of 35. Death was attributed to a heart attack. A native of Moultrie, Dr. Holmes was born April 27, 1919.

He received his education in the Moultrie public schools, Emory University and Emory University School of Medicine. He interned at Emory University Hospital and Grady Memorial Hospital, Atlanta. During World War II, he served as a captain in the Army Medical Corps.

Dr. Holmes had practiced in Moultrie for the last eight years and had found time, in addition, to participate in many civic enterprises. He was a director in the Moultrie Baseball Club, a member of the Colquitt County Board of Health, and was serving his second successive year as president of the Little League baseball organization. He was a past president of the Colquitt County Medical Society.

He is survived by his wife, the former Mary Frances Broach of Atlanta; twin sons, Jim and John, and a daughter, Florence.

Funeral services were held on April 15 at the First Presbyterian Church in Moultrie. Members of the Colquitt County Medical Society served as honorary pallbearers. Burial was in Westview Cemetery.

LINUS J. MILLER, Atlanta, died April 8, 1955, at the age of 44. Dr. Miller was chief anesthesiologist at Crawford W. Long Memorial Hospital.

A native of Pennsylvania, he received his M.D. degree from the University of Pittsburgh and later studied anesthesiology at Hartford (Connecticut) Hospital. He came to Atlanta in 1940 to practice anesthesiology privately, and for the last five years was on the staff of Crawford W. Long Memorial Hospital.

Surviving are his wife, his parents, Mr. and Mrs. Earl C. Miller of Tucker, and one sister, Mrs. Homer Starr of Utah.

Funeral services were conducted on April 10th at Spring Hill in Atlanta; burial was in Decatur City Cemetery.

SOCIETIES

The SECOND DISTRICT MEDICAL SOCIETY held its semi-annual meeting on April 6, 1955, in Camilla. Officers for the year were elected, and they are as follows: president, Mervin B. Wine, Thomasville; vice-president, Harry Baxley, Donalsonville; and secretary-treasurer, Julian B. Neel, Thomasville. The scientific session consisted of papers presented by Bernard P. Wolff, Atlanta — "The Hyperventilation Syndrome", Albert S. Trulock, Albany—"Diverticulitis of the Colon", and William L. Bridges, Jr., Tifton—"Treatment of Meningitis in Children". Mitchell County Medical Society and the Auxiliary were hosts for the meeting and the social hour and dinner held at the American Legion Home immediately following the business session.

The SIXTH DISTRICT MEDICAL SOCIETY held its semi-annual meeting in Forsyth on Wednesday, April 13th, at 2:00 p. m. The scientific session had as its theme pediatrics problems. Appearing on the program were

T. M. Hall, Macon—"Anxiety Reactions in the Chronically Ill Convalescent Child", Walter Barnes, Macon—"Torsion of the Legs in Children", William F. Friedewald, Atlanta—"Poliomyelitis: Pathogenesis and Prophylaxis", Calder B. Clay, Jr., Macon—"Intestinal Obstruction in the Neonatal Period", and Robert Clark, Macon—"Differential Diagnosis of the Enlarging Head in Infancy". The Woman's Auxiliary met at the same time at the home of Mrs. Walter Bramblett, Forsyth, and members of the two organizations were entertained at a social hour and barbecue at the home of the George Alexanders of Forsyth after the business sessions. Special guests at this meeting were the MAG secretary-treasurer, David Henry Poer, Atlanta, and executive secretary, Mr. Milton D. Krueger, also of Atlanta.

BIBB COUNTY MEDICAL SOCIETY met on April 5, 1955, at Pinebrook Inn, Macon. Principal speaker was E. Frank McCall, Jacksonville, Fla., chief of obstetrics at St. Vincent's Hospital and a staff member of Hope Haven Hospital and Medical Center Hospital in Jacksonville. The topic of Dr. McCall's address was "Medical and Surgical Approaches to the Problem of Female Infertility".

The GEORGIA MEDICAL SOCIETY met on April 7, 1955, to hear an address by Coleman Mopper, Detroit dermatologist. Dr. Mopper's subject was "Some Dermatologic Manifestations of Internal Conditions". A native Savannahian, Dr. Mopper is assistant professor of dermatology at Wayne University College of Medicine in Detroit. He is a graduate of the University of Georgia and the Medical College of Georgia.

At the April meeting of the FULTON COUNTY MEDICAL SOCIETY, April 7, 1955, a panel of Atlanta doctors reviewed 100 years of medicine and predicted fascinating uses of radioactive isotopes and hormones in medicine in the future. The meeting marked the 50th anniversary of the society. Herbert S. Alden, Atlanta, was moderator. Speakers on the program included Charles S. Jones, C. C. Aven, Floyd McRae, Jr., W. Perrin Nicolson, Jr., W. E. Person, Walter Bell, T. F. Sellers, Leo P. Daly, George Noble, R. Hugh Wood, Jack C. Norris, Albert Evans, Calvin Weaver, and Mrs. James N. Brawner.

The SOUTHEAST GEORGIA MEDICAL SOCIETY, comprising physicians from Treutlin, Toombs, Montgomery, and Wheeler Counties was organized on Wednesday, April 20, 1955, at a meeting at the Vidalia Country Club. J. E. Mercer, of Vidalia, was elected president of the new organization, and John D. McArthur, Lyons, was elected secretary. A scientific program was presented by Milford B. Hatcher, Macon, who talked on "Gallbladder Disease". Lee Howard, 1st District Councilor, and Mr. John F. Kiser, of the MAG Headquarters Office, also spoke. The next meeting of the organization was set for May 25, 1955, at the Country Club in Vidalia. In the meantime, members of the Tattnall County Medical Society will be voting as to whether or not they want to join with this new society. Present at this meeting were W. H. Bedingfield, H. I. Conner, V. Lee Darby, O. S. Gross, R. H. DeJarnette, J. E. Mercer, J. E. Barfield, all of Vidalia; W. W. Aiken and John D. McArthur, Lyons; A. J. Yates, Soperton; Morris Kusnitz, Alamo; James Hunt, Mount Vernon; and J. M. Hughes, Glenville.

The WARE COUNTY MEDICAL SOCIETY met April 7, 1955, in Waycross at the Okefenokee Golf Club. Speakers at the meeting were W. L. Flesch and W. P. Bates; their topic—"Sterility Problems". T. J. Ferrell, Arthur M. Knight, Jr., and Neal Yeomans also discussed various phases of infertility. Malcolm McGoogan, W. B. Bates, and Neal F. Yeomans were hosts for the meeting.

PERSONALS

First District

John H. Angell, Savannah, announces the opening of his office for the practice of obstetrics and gynecology at 126 East Taylor Street. Dr. Angell was born in Baltimore and has lived there most of his life. He is a graduate of Johns Hopkins University and the Johns Hopkins Medical School in 1947. He interned at Barnes Hospital, St. Louis, and returned to Johns Hopkins in 1948 for his residency training in gynecology and obstetrics. He was commissioned a captain in the Army Medical Corps in 1950 and served with the Army until 1953, at which time he returned to Johns Hopkins to complete his training.

ELLISON R. COOK, III, Savannah, addressed the Savannah Blood Donor Gallon Club at its meeting on April 13th; his subject was, "Blood as a Medicine and Its Increasing Need". The principal business of the meeting was to recognize the civilians who have donated a gallon of blood through the Red Cross program during the period November 5-March 25.

The *Journal* regrets to announce the death on March 23, 1955, of Leon G. Moye, Adrian, father of ROBERT J. MOYE, Adrian.

Second District

JOSEPH P. DOYLE, Camilla, was one of the Georgia physicians who attended the closed circuit television showing in Jacksonville, Fla., on the results of the Salk Polio Vaccine field tests.

Announcement has been made of the forthcoming marriage of Miss Marion Brim Edwards to ROBERT CHRISTOPHER RICHARDSON, Albany. The wedding will take place on June 4 at 5:30 o'clock in the First Methodist Church of Albany.

Third District

Two graduates of the class of 1954 at the Medical College of Georgia plan to practice in Vienna following completion of their internships in Macon early this summer. They are J. T. Christmas, a native of Dooly County, and R. S. Robinson, Carrollton. Work has already begun on construction of an office building for the two physicians who will practice together.

WILLIS P. JORDAN, SR., Columbus, will serve as chief of the medical staff of Columbus City Hospital for 1955-56. He succeeds GEORGE R. CONNER; HARRY H. BRILL was re-elected secretary. J. A. Thrash (see below) Columbus City Hospital administrator, made several announcements and reported that the City Hospital will receive its full quota of 10 interns under the matching program and that it will be the only hospital in the state to receive a full quota.

J. A. THRASH, Columbus, was elected president of the Georgia Hospital Association for the present year. He

Personals

will serve until the next meeting of the association which will be held in Atlanta in February 1956.

Fourth District

H. L. BARKER and PHIL C. ASTIN, JR., Carrollton, attended the closed circuit television showing in Atlanta on the Salk Polio Vaccine field tests. This show constituted the first official announcement of the vaccine's approval, and it was seen by 52,000 physicians throughout the nation.

E. JORDAN CALLAWAY, Covington, was chairman of the committee appointed to investigate the feasibility of the Newton County Hospital's participation in the Eye Bank Program. The hospital is giving full cooperation to the Eye Donor Drive sponsored by the Covington, Oxford, and Mansfield Lions Clubs. Surgeons on the medical staff of the hospital offered their services gratis in the operation for removal of eyes donated, at death, by the eye donors to the Eye Bank for Restoration of Sight. Eyes donated from Newton County will be sent to Ponce de Leon Infirmary in Atlanta—the nearest affiliate of the National Eye Bank for Restoration of Sight, Inc., with headquarters located in New York City.

CURRAN S. EASLEY, LaGrange, vice-president of the board of trustees of City-County Hospital (LaGrange), was elected president at a recent meeting of the board. He succeeds Mr. Lester Sayers who resigned. Dr. EASLEY, WILLIAM B. FACKLER and H. H. HAMMETT, JR., represent the Troup County Medical Society on the board.

M. M. HEAD, Zebulon, is a director of the recently formed Georgia securities organization known as Bankers Securities Corporation. Offices for the company have been established at 314 Glenn Building, Atlanta.

Fifth District

The Southeastern Hospital Conference was held at the Biltmore Hotel, Atlanta, April 20 through 22. The conference is a six-state meeting of hospital associations in Alabama, Georgia, Florida, Louisiana, Mississippi, and Tennessee. Allied groups meeting at the conference include: Southeastern Hospital Conference of Dietitians, Southeastern Assembly of Nurse Anesthetists, Southeastern Hospital Conference of Medical Record Librarians, Southeastern Society of Hospital Pharmacists, and the Southeastern Hospital Conference of Woman's Auxiliaries. Charles Mayo of the Mayo Clinic in Rochester, Minn., was one of the featured speakers on the program.

The Eastern Surgical Association held its annual meeting on April 8, 1955, at Emory University Hospital with the Emory Department of Surgery as host. FLOYD MCRAE, Atlanta, presided at this meeting of the association; Emory professors who presented papers were R. HUGH WOOD, SAM A. WILKINS, JR., WILLIAM GALVIN, J. D. MARTIN, JR., FRED C. SMITH, OSLER A. ABBOTT, and WILLIAM C. MCGARITY. A luncheon for those in attendance was given on Friday, April 8, in the Whitehead Memorial Room at Emory, and the surgeons were guests at dinner at the Piedmont Driving Club. Members of the staff of Piedmont Hospital, Atlanta, presented a program of papers, operations, and demonstrations on Saturday, April 9, for the Eastern Surgical Association. Physicians from Piedmont who

participated in the program were as follows: LAWSON THORNTON, PHILLIP WARNER, WILLIAM E. MITCHELL, JOHN T. AKIN, CHARLES S. JONES, THOMAS E. REEVE, LUTHER ROLLINS, JR., EDWARD J. WAITS, RICHARD MARGESON, DUNCAN SHEPARD, and DAVID HENRY POER.

HEINZ BAUER, Decatur, pathologist on the staff of Emory University Hospital, has been re-elected chairman of the troupe committee of Troop No. 18, Boy Scouts of America. Troop No. 18 is sponsored by Glenn Memorial Methodist Church.

CHARLES GALLOWAY BOLAND, Atlanta, announces the removal of his offices (effective April 1, 1955) to 367 Parkway Drive, N. E., Atlanta.

ROGER W. DICKSON, Atlanta, was guest speaker at the regular monthly meeting of the Cartersville Chapter, Georgia Association for the Help of Retarded Children, held in April. He talked on "The Emotional Needs of Children". Dr. Dickson is a member of the Board of Trustees of the Fairhaven School for Exceptional Children and first vice-president of the Georgia Association for the Help of Retarded Children.

C. STEDMAN GLISSON, Atlanta, was elected president of the Emory University Medical Alumni Association at the annual banquet meeting of the association during recent homecoming activities at Emory. Other officers elected are: Odell L. Dannenbrink, Bronxville, N. Y., vice-president; and A. EUGENE HAUCK, Atlanta, secretary-treasurer. W. E. PERSON, Atlanta, of the Emory medical class of 1901, was honored for his service to the medical alumni association.

BRUCE LOGUE and CLYDE TOMLIN, both of Emory University, will edit the section on cardiovascular disease for the Annual Review of Medicine for the year 1955 prepared by the Stanford University Press.

Sixth District

John W. Acree, Macon, will go to Hiawassee on or after July 1, 1955, to practice medicine and surgery with offices in the Lee M. Happ, Jr., Memorial Hospital. Dr. Acree was born in Calhoun, and is the son of M. A. ACREE of that city. He received his pre-medical education at West Georgia College and Emory University, and his M.D. degree from the Medical College of Georgia, Augusta. He interned at the Macon City Hospital where he is now taking special training in obstetrics, gynecology, and pediatrics.

GEORGE H. ALEXANDER, Forsyth, attended the recent meeting of the American Academy of General Practice in Los Angeles. Dr. Alexander is president of the Georgia Academy of General Practice.

Seventh District

No news received.

Eighth District

H. T. ADKINS, Waycross, Ware County Health Commissioner, discussed the Salk polio vaccine on an Exchange Club forum recently. The program was broadcast over station WAYX.

Byron S. Davis, Valdosta, has assumed his duties as pathologist for the newly opened Pineview General Hospital in Valdosta. Dr. Davis is a graduate of the Emory University School of Medicine; he interned at Grady Memorial Hospital and Emory University Hospital. He

has received further specialized training at the VA Hospital in Atlanta; Wadley Research Institute, Baylor Hospital, Dallas, Texas; and the Armed Forces Institute of Pathology in Washington and New York.

JAMES M. HICKS, Brunswick, attended the Gill Memorial Eye, Ear, Nose and Throat convention in Roanoke, Va., April 4-19, 1955.

R. A. PUMPELLY and FRED M. HARPER, Jesup, went to Jacksonville, Fla., for the closed circuit television report on April 12th, on the Salk Vaccine field tests.

NEAL F. YEOMANS, Waycross, was one of the physicians who went to Nevada to participate in the training program at the Nevada Test Site in connection with the present atomic test series. Approximately 25 persons from all sections of the country were nominated by the Federal Civil Defense Administration to participate in field demonstrations during the FCDA "Operation Cue".

Ninth District

Congratulations to T. C. BOSWELL, Tate, and Mrs. Boswell on the birth of a son, T. C., Jr., on March 12, 1955.

Dr. and Mrs. RUPERT HAROLD BRAMBLETT, Cumming, announce the birth of a son, Walker Hugh, at the Mary Alice Hospital in Cumming on April 8, 1955.

JOHN W. MAULDIN, Lawrenceville, has opened offices in Lawrenceville for the practice of medicine. Dr. Mauldin graduated from Presbyterian College in South Carolina and received his M.D. degree from the Medical College of Georgia in 1946. He received postgraduate training at University Hospital, Augusta, and at Cook County Hospital, Chicago. He comes to Lawrenceville from Alma. Dr. Mauldin is a member of the Ware County Medical Society and is now serving his second term as chairman of the State Medical Education Board.

Tenth District

G. LOMBARD KELLY, Augusta, addressed the West Virginia Academy of General Practice in Charleston on April 16, 1955. His subject was "Problems of Libido and Potentia Encountered by the General Practitioner".

W. C. MCGEARY, Madison, has announced the closing of the McGeary Hospital, first opened in 1926, effective April 15, 1955. Both Dr. McGeary and his son Dr. McGeary, Jr., will continue to have their offices in the hospital building.

J. H. ROBBINS, Director of Student Health at the Gilbert Memorial Infirmary, University of Georgia, Athens, announces the appointment of William F. Encke, formerly of Inverness, Miss., as Assistant Director of Student Health. The appointment of Dr. Encke now gives the University two full-time physicians who, with the assistance of two senior medical students from the Medical College of Georgia, give the University of Georgia one of the finest departments of student health in the country. Also new equipment has been installed in the 43-bed infirmary, and the out-patient facilities have been renovated.

News from the Southern Medical Association

There are two matters that all should attend to at once regarding the coming meeting at Houston: *First*, send in your request for hotel reservations. The headquarters hotel will be the fabulous *Shamrock*. There are many other splendid hotels also available; the reservations will be made on "first applied-first confirmed" basis. *Second*, those who anticipate exhibits should send in their requests at once.

Blanks for exhibit space may be obtained from headquarters in Birmingham, Ala. Those anticipating papers should contact the section chairman.

The meeting is shaping up rapidly, and it will be a memorable one. Those Texans really understand what the word hospitality means. Again we say: "On to Houston": Nov. 14-17, 1955.

Do You Receive "American-Soviet Facts"?

INFORMATION REACHING the American Medical Association indicates that numerous physicians throughout the country recently have received a mimeographed publication called "American Soviet Facts," containing 21 half-pages of "up-to-date information" on "Health and Medical Care in the U.S.S.R." This material is published by the National Council of American-Soviet Friendship, 114 East 32nd Street, New York 16, New York, one of the leading communist propaganda agencies in the United States.

As a safeguard against any suspicions of communist sympathies, physicians who wish to keep the record straight should write to the National Council of American-Soviet Friendship, requesting that their names be taken off that organization's mailing list. A carbon copy of the letter should be sent to the nearest office of the Federal Bureau of Investigation or to the F.B.I. in Washington, along with the propaganda material received. This precaution is advised because records are kept of persons receiving communist literature for any considerable length of time.

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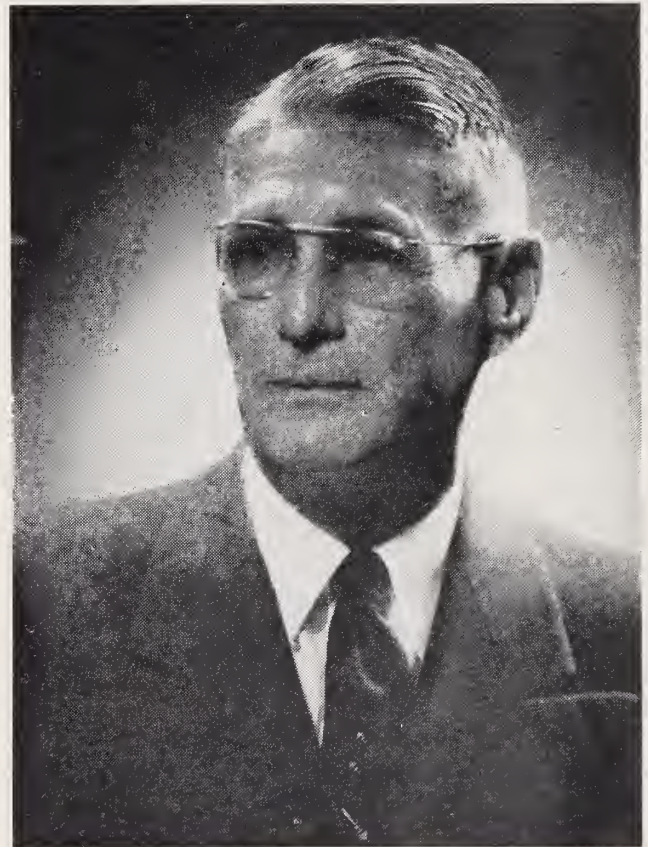
President's Address

105th Annual Session

of the

Medical Association of Georgia

PETER B. WRIGHT, M.D., Augusta, Ga.



Peter B. Wright, President
1954 - 1955

DURING the past two years I have come to increasingly learn and realize that the trials and tribulations of the doctor are not peculiar to any one of us. We have experiences and problems arising out of the practice of our profession which are common to all of us. Some of these experiences and problems are pleasing and not difficult to solve, while others are depressing, and some are practically impossible to correctly diagnose and remedy.

It is the former group that gives us pleasure and an increased ego while it is the latter group which makes us melancholic and dejected. I realize that the pleasures which we derive from the practice of our profession and the dejections which we likewise derive from some of our experiences are universal among those of us who have devoted our lives and our talents to the practice of medicine.

Listening to the experiences of many of my colleagues and hearing their different and varying views concerning the practice of medicine the thought came to me "*Why did we study medicine?*"

Surely it was not because we became interested in the "Cult of the Serpent of Aesculapius," nor the Medical Schools of Cos where Hippocrates was born, nor the Hippocratic collections which, if not too informative, certainly are very interesting.

The most interesting and most famous item of this collection is the *Aphorisms*, conceded to have been written by Hippocrates. The style of the *Aphorisms* is suggestive of an aged physician narrating the experiences of his professional life. These are a series of related experiences which later were adopted as popular proverbs. One which strikes keenly is: "Not only must the physician be ready

to do his duty, but the patient, the attendant, and the external circumstances must conduce to the cure."

The practitioners of medicine working with the benefit which can be derived from the related medical organizations can in the final analysis produce the "external circumstances" which Hippocrates said must conduce to the cure.

Certainly we did not study medicine because we became interested in the four primary and opposite fundamentals as described by Aristotle. Namely: the hot, the cold, the wet and the dry.

Nor was the work of the then great anatomist, Herophilus, and that of the physiologist, Erasistratus, of the Alexandrian School, influential factors in our decision to study medicine.

The three spirits as described by Galen, namely: the Natural Spirits formed in the liver and distributed by way of the venous system; the Vital Spirits formed in the heart and sent out through the arteries; and the Animal Spirits formed in the brain and conducted by the nerves, attract interest. But I seriously doubt that these three spirits or any one of them exerted any influence upon prospective students in reaching a decision to study medicine.

None of the above mentioned abstracts from ancient history could have been a deciding factor with us because with practically no exception, the potential medical student never reads or hears of them before he has reached his decision to study medicine.

Andreas Vesalius, the father of anatomy in modern medicine, exerted a marked influence upon the doctors of his day, but I doubt that the inspiration of his work, even at that date, reached into the group of prospective students of medicine.

Utilizing the writings of Vesalius, the noted French surgeon, Ambrose Pare, contributed much to the progress of surgery.

The discovery by Harvey of the real circulation of the blood was an outstanding step forward. However, I am quite certain that neither of these two important men nor their work was responsible for our decision to undertake the study of medicine.

Edward Jenner, who developed "Cow Pox" as an immunization against small pox, made a tremendous contribution, as did Pasteur, Lister and Koch in their studies and discoveries in immunity to disease and infection, but I am quite sure that none of these contributed to our decision to study medicine.

I had never heard of Rudolf Virchow, whom I now consider to be the father of pathology, until I reached the sophomore year at medical college, and I would venture to say that he had never been heard of by but few of you either, until you had reached that point in your medical education.

The biographical sketches of more modern men and their writings may have had some inspirational effect upon us. These men had made contributions known to some of us and known to all of our professors, but the real and direct influence which they may have exerted upon our decisions to study medicine in the first place is doubtful. The men of whom I now speak are many, but may be symbolized by the names of Osler, Holmes and Sims. However, I am quite sure that these possible influences were not known to the great majority of us until we were in medical school or had been graduated.

Some of the more likely reasons why we studied medicine are: (1) That we had a father who was a doctor. I had that privilege, and he not only inspired me but instilled in me a true love for the profession. My total admiration of him and a close father-son relationship made me have for my ambition, "to become a doctor." (2) Admiration for the family doctor or for some other physician of prominence who cured us or one of our loved ones and consoled the other members of the family, gaining our confidence and even our devotion, may well have been the inspiration. (3) There could have been an inherent desire or even an acquired desire to be a doctor. (4) There may have been an irresistible scientific inclination. (5) We may have been influenced by kind heartedness and an anxiousness to relieve human suffering. (6) We may have been activated by a desire to contribute to the profession into which we were to put our souls. (7) Our inspiration may have been to uphold what was, and still is to us, the greatest profession. (8) The miracles performed by the "Great Physician," of which we learned in early life, could have been the inspiring factor. (9) It may have been an abiding and profound interest in our fellowman. (10) We may have had a desire to occupy a position in society whereby we might make our ambitions for our selected profession audible.

There are probably other good reasons, but I sincerely hope that no one will ever study medicine with an idea of exploiting the profession.

A quotation from the Hippocratic Oath which is worthy of repeated repetition is: "I will look upon him who shall have taught me this art even as one of my parents."

Now that we have studied medicine and are doctors in the strictest sense; "*Why have doctors banded together and formed medical societies?*" is another question.

Is it because we like each other's company and can enjoy social life together? Or is it that our wives are fond of each other and promote the social side of life? I am quite sure that neither of these is the reason.

As doctors, we have had experiences common to all, to the distinguished and to the unknown alike, which are often more informative than book knowledge and it is the exchange of these experiences that draws us closer to each other.

When things go well with us, we have receptive ears to speak into and our colleagues share our joy with us. When things go wrong and we are downcast and sad, we have those same listeners who share our grief and sympathetically try to encourage us. It is no wonder, therefore, that we, who have gained the confidence and faith of people to the point of having them place their lives in our hands, are grouped together so fraternally.

Experiences of the past may be good or bad, happy or sad, and about these we can reminisce together and in so doing we afford to each other the benefit of our joint experiences.

Experiences encountered daily concern the facts which we use as a basis for our method of practice, and it is these facts which call forth consultations, and these consultations in turn, if properly held, bind us more tightly together.

Our dreams of new experiences in the coming years give us ambition and arouse hope for the future and develop in us faith in posterity.

Without each other and without sharing our common experiences in the daily practice of our profession, medicine as we know and enjoy it would become dull, dry and withered.

Our county societies represent the local level where men of a community may put forward their opinions and ideas and at the same time have the pleasure of social contacts with their colleagues. It is at this level where any one of us may express himself fully, and, if he is not satisfied with a decision of his county society, he may through his local delegate to the state association be heard upon a state wide basis. Should no satisfactory conclusion to the matter be reached on a state basis, then any one of us may, through the state delegates to the American Medical Association, be heard on a national level.

The American Medical Association, therefore, is a federation of county, state and territorial societies which was organized by doctors in 1847, and whose aim was and is to promote the art and science of medicine and the betterment of the public health. Each state may have one delegate to the American Medical Association for each one thousand members in that state.

The many councils and committees of the American Medical Association and your county and state associations are constantly at work to assure us of receiving amongst other things, pure foods, safe and effective drugs, and properly accredited medical

schools and hospitals.

The American Medical Association does not receive federal money, but is financed through its members and journals. It assembles pertinent information concerning every doctor, medical college and hospital in an effort to standardize medical education and hospital personnel; approving them on the one hand when they meet the required standards but condemning them, on the other hand, when they do not meet these standards.

The American Medical Association has set a standard for medical education and the adequacy of hospitals. Therefore, medical schools and hospitals must meet these required standards in order to obtain recognized accreditation. It is not the building nor altogether the equipment but the personnel which effects the curing of the sick and the teaching of medical students and house staff.

The American Medical Association has a Code of Ethics which if abided by, the doctor is assured of free enterprise and his self-respect. When the code is properly respected by all of the medical profession, there should be no internal strife in the profession.

Doctors rightfully enjoy personal independence and like to practice according to the dictates of their own consciences and not along lines or according to methods proposed by others, doctors or lay people, but especially those who do not practice medicine and know nothing of doctor-patient relationship.

In short, there is no need for strife within the medical profession. Such strife can only be made by the members of these associations and without that strife and with a united membership we can far better combat the outside forces which are today making a dangerous threat against the medical profession.

We are confronted with many inroads of socialized medicine into our profession, and we should not only always remember our predecessors and be grateful for our heritage but also realize that we must defend medicine now, as never before, knowing that our successors can do a better job of keeping the "ship of medicine" on an even keel if they are given deep and still waters on which to sail.

By our posterity in medicine, by ourselves, by the public and by those noble and principled doctors through whose efforts and examples and teachings we have been handed such a treasured prize and such a profound responsibility, we are challenged to untiringly defend and promote the "Principles and Practice of Medicine" in order to maintain the high standards of medicine and further the great and lasting beneficial effects which our profession has bestowed upon mankind.

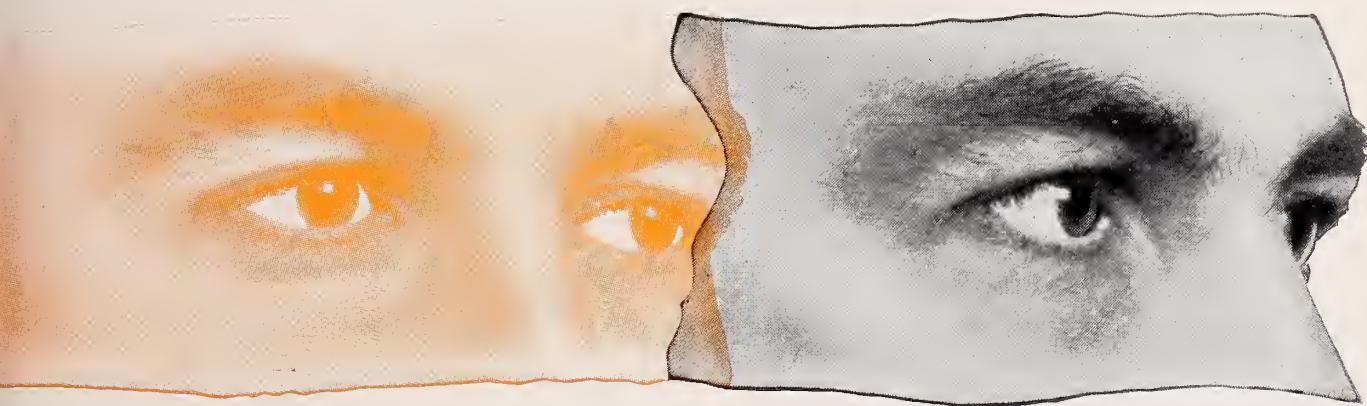
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Official Proceedings

105th Annual Session

of the

MEDICAL ASSOCIATION

of GEORGIA

Augusta, May 1-4, 1955

First Session, House of Delegates

SUNDAY, MAY 1, 1955

The House of Delegates of the Medical Association of Georgia was called to order by President Peter B. Wright at 5 p.m. in the Crystal Room of the Bon Air Hotel, Augusta.

President Wright called upon C. H. Richardson, Sr., Macon, to give the invocation.

Credentials Committee Chairman Eustace A. Allen, Atlanta, then called the roll from the official MAG House of Delegates Roster. Upon completion of the roll call Dr. Allen reported a quorum of the members of the House of Delegates present.

Attendance

BALDWIN: Wallace Gibson; BEN HILL-IRWIN, Herman Dismuke; BIBB: Henry H. Tift, J. B. Kay, Samuel E. Patton, Allan A. Cole, George H. Alexander, Milford B. Hatcher; BULLOCH-CANDLER-EVANS: A. J. Mooney; CARROLL-DOUGLAS-HARALSON: R. L. Denney; GEORGIA MEDICAL SOCIETY: John L. Elliott, W. H. Fulmer, Lee Howard, Jr., Ruskin King; CHATTOOGA: W. P. Martin; CHEROKEE-PICKENS: C. J. Roper; CLARKE-MADISON-OCONEE: J. A. Greene, M. A. Hubert; CLAYTON-FAYETTE: T. J. Busey; COBB: W. C. Mitchell; COFFEE: Sage Harper; DECATUR-SEMINOLE: E. M. Griffin; DEKALB: John T. Leslie; DOUGHERTY: Glenn F. Seymour, William M. Field; ELBERT: D. N. Thompson; EMANUEL: R. J. Moye; FLOYD: Stephen D. Smith; FULTON: J. D. McElroy, W. M. Moncrief; Alton V. Hallum, C. Purcell Roberts, Lester Rumble, Jr., Linton H. Bishop, Jr., Tully T. Blalock, McClaren Johnson, A. O. Linch, George Fuller, Harold P. McDonald, Joseph L. Rankin, B. L. Shackelford, Joseph C. Massee, E. Van Buren, H. Walker Jernigan, John W. Turner, Haywood N. Hill, E. A. Bancker, J. Harry Rogers, W. W. Bryan, Samuel A. Anderson, Irving L. Greenberg; GLYNN: J. B. Avera, Bert H. Malone; GORDON: Lewis R.

Lang; HABERSHAM: J. L. Walker; HALL: W. C. McCarver, Rafe Banks; HANCOCK: George F. Green; HART: J. Hubert Milford; JACKSON-BARROW: A. A. Rogers, Jr.; JEFFERSON: John J. Pilcher, Jr.; JENKINS: A. P. Mulkey; LAURENS: John A. Bell, Jr.; McDUFFIE: A. G. LeRoy; MERIWETHER-HARRIS: Calvin Jackson; MORGAN: C. H. Dickens; MUSCOGEE: A. B. Conger; NEWTON: Clarence B. Palmer; OCMULGEE: Maurice F. Arnold; POLK: D. W. Schmidt; RABUN: George H. Boyd, Jr.; RANDOLPH-TERRELL: W. D. Martin; RICHMOND: Thomas W. Goodwin, David R. Thomas, Jr., Stephen W. Brown, Charles M. Mulherin, Robert C. Major; SCREVEN: Gerald B. Hogsette; SOUTH GEORGIA: F. G. Eldridge; SOUTHWEST GEORGIA: Warren C. Baxley; SPALDING: Virgil P. Williams; STEPHENS: Robert E. Shiflett; SUMTER: Carl P. Savage; THOMAS: Rudolph F. Bell, William McCollum; TIFT: C. S. Pittman; TROUP: Charles T. Cowart, H. H. Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Fred H. Simonton; WALTON: Lynn M. Huie; WARE: W. L. Pomeroy, Leo Smith; WARREN: H. B. Cason; WASHINGTON: F. T. McElreath, and WHITFIELD: H. L. Erwin.

County Medical Societies not represented at this House of Delegates session were as follows:

ALTAMAHA, BARTOW, BLUE RIDGE, BROOKS, BURKE, COLQUITT, COWETA, CRISP, DOOLY, FORSYTH, FRANKLIN, GRADY, GWINNETT, HOUSTON-PEACH, JASPER, LAMAR, MITCHELL, MONTGOMERY, TATTNALL, TAYLOR, TELFAIR, TOOMBS, WAYNE, WILKES and WORTH.

Other members of the House of Delegates in attendance were:

Peter B. Wright, H. Dawson Allen, William Harbin, Willard R. Golsan, Milford B. Hatcher, David Henry Poer, Lee Howard, Sr., George R. Dillinger, J. W. Chambers, Henry H. Tift, Neal F. Yeomans, W. Bruce Schaefer, C. H. Richardson, Sr., Eustace A. Allen, Spencer A. Kirkland, Ralph H. Chaney, William R.

Dancy, Grady N. Coker, C. L. Ayers, C. F. Holton, and the Messrs. Krueger and Kiser of the headquarters office staff.

In compilation of attendance taken from the official roll, 54 county medical societies were represented by their duly elected delegates. Twenty-six county medical societies were not represented at this session. Of a total of 136 delegates from their respective county medical societies, the official roll showed 96 delegates present at this session.

Reference Committees

President Wright appointed the following House of Delegates Reference Committees.

Reference Committee No. 1: Ruskin King, Savannah, Chairman; Leo Smith, Waycross, Vice-Chairman; William Harbin, Rome; R. L. Denney, Carrollton; W. B. Dillard, Cartersville; Milford B. Hatcher, Macon; M. A. Hubert, Athens; A. J. Mooney, Statesboro; Samuel E. Patton, Macon, and C. J. Roper, Jasper.

Reference Committee No. 2: Henry H. Tift, Macon, Chairman; Lee Howard, Jr., Savannah, Vice-Chairman; H. L. Cheves, Union Point; C. F. Holton, Savannah; J. B. Avera, Brunswick; R. C. Major, Augusta; C. L. Ayers, Toccoa; W. C. Mitchell, Smyrna; Julian K. Quattlebaum, Savannah; and J. L. Walker, Clarkesville.

Reference Committee No. 3: J. M. Byne, Jr., Waynesboro, Chairman; T. A. Sappington, Thomaston, Vice-Chairman; R. J. Moye, Adrian; M. F. Arnold, Hawkinsville; A. B. Conger, Columbus; W. H. Fulmer, Savannah; Lewis R. Lang, Calhoun; W. C. McCarver, Gainesville; C. M. Mulherin, Augusta; and Irving L. Greenberg, Atlanta.

Reference Committee No. 4: Grady N. Coker, Canton, Chairman; James A. Green, Athens, Vice-Chairman; John A. Bell, Dublin; Linton H. Bishop, Jr., Atlanta; Rudolph F. Bell, Thomasville; H. B. Cason, Warrenton; C. S. Pittman, Jr., Tifton; John T. Leslie, Decatur; A. G. LeRoy, Thomson; and Virgil B. Williams, Griffin.

Reference Committee No. 5: W. L. Pomeroy, Waycross, Chairman; John W. Turner, Atlanta, Vice-Chairman; A. M. Phillips, Macon; W. W. Bryan, Atlanta; Charles T. Cowart, LaGrange; Gerald B. Hogsette, Sylvania; F. G. Eldridge, Valdosta; Lynn M. Huie, Monroe; Stephen D. Smith, Rome; and D. W. Schmidt, Cedartown.

Reference Committee No. 6: B. L. Shackleford, Atlanta, Chairman; Enoch Callaway, LaGrange; Fred H. Simonton, Chickamauga; Glenn Seymour, Albany; J. J. Pilcher, Wrens; and J. W. Chambers, LaGrange, *Ex-officio*.

For the information of the House of Delegates, President Wright reported that Reference Committee No. 6 was appointed upon the recommendation of the Council of the Medical Association of Georgia to consider the report of the Constitution and By-Laws Committee.

Credentials Committee

President Wright appointed the Credentials Committee as follows:

Eustace A. Allen, Atlanta, Chairman; Willard R. Golsan, Macon; and R. C. McGahee, Augusta. Alternates appointed to this committee were R. C. Major, Augusta, and Milford B. Hatcher, Macon.

Tellers Committee

President Wright appointed the following members to the Tellers Committee:

Ralph Chaney, Augusta, Chairman; William R. Dancy, Savannah; and M. M. Head, Zebulon.

President Wright announced that the Chair would then entertain nominations for the offices of Speaker and Vice-Speaker of the House of Delegates. J. W. Chambers, LaGrange, nominated Thomas W. Goodwin, Augusta. The nomination was seconded by Harold C. McDonald, Atlanta. It was then moved and seconded that nominations be closed. By unanimous vote Dr. Goodwin was elected Speaker of the House of Delegates.

On a motion by William Harbin, Rome, seconded by H. L. Cheves, Union Point, Fred H. Simonton, of Chickamauga, was nominated Vice-Speaker of the House of Delegates. The motion passed unanimously.

Speaker Goodwin then addressed the members of the House concerning the "ground rules" for the conduct of business before the House.

Speaker Goodwin then remarked:

"I certainly wish to express my own appreciation to each county medical society and their elected representatives in this House for their interest and attendance. As our Association matures, our business matters become more complex, and I sincerely hope that, as the legislative body of the medical profession in Georgia, we may lead our colleagues to righteously strive to fulfill our obligations as practitioners of the healing arts to the citizenry of this state. I wish to instruct each delegate to report fully the action of this House to his constituency in his county medical society. Thank you."

Speaker Goodwin then called for the reading and adoption of minutes. The minutes of the House of Delegates meeting held in conjunction with the 104th Annual Session, Macon, May 2-5, 1954, were published in the June 1954 *Journal*, and the minutes of the special called meeting of the House of Delegates held in Macon, December 12, 1954, were published in the January 1955 *Journal*. It was moved and duly seconded and adopted that these minutes be approved as published and were so approved by the House of Delegates at this session.

Speaker Goodwin then introduced Dean Stewart, fraternal delegate from Florida to the 105th Annual Session of the Medical Association of Georgia.

Speaker Goodwin reported the next item of business was the reports before the House.

(A cross reference of the officer, committee chairman, minority reports, addendums, and resolutions introduced at this session are listed below with the reference committee to which the report was referred. The full report and action by the reference committee and the House of Delegates are listed under the proceedings of the Second Session of the House of Delegates. See pages 262-)

Reports of Officers

President—Peter B. Wright, Augusta—Reference Committee No. 1—See page 262.

President-elect—H. Dawson Allen, Jr., Milledgeville—Reference Committee No. 2—See page 272.

Immediate Past President—William Harbin, Rome—Reference Committee No. 3—See page 282.

First Vice-President—Willard R. Golsan, Macon—Reference Committee No. 4—See page 290.

Second Vice-President—Milford B. Hatcher, Macon—Reference Committee No. 4—See page 291.

Secretary—David Henry Poer, Atlanta—Reference Committee No. 5—See page 299.

Treasurer—David Henry Poer, Atlanta—Reference Committee No. 5—See page 301.

AMA Delegates—C. H. Richardson, Sr., Macon; Eustace A. Allen, Atlanta; and Spencer A. Kirkland, Atlanta—Reference Committee No. 4—See page 291.

First District Councillor—Lee Howard, Savannah—Reference Committee No. 1—See page 263.

First District Vice-Councillor—Charles T. Brown, Guyton—Reference Committee No. 1—See page 264.

Second District Councillor—George R. Dillinger, Thomasville—Reference Committee No. 1—See page 264.

Second District Vice-Councillor—Carl S. Pittman, Sr., Tifton—Reference Committee No. 1—no report.

Third District Councillor—W. G. Elliott, Cuthbert—Reference Committee No. 1—See page 265.

Third District Vice-Councillor—Guy J. Dillard, Columbus—Reference Committee No. 1—no report.

Fourth District Councillor—J. W. Chambers, LaGrange—Reference Committee No. 2—See page 273.

Fourth District Vice-Councillor—Clarence B. Palmer, Covington—Reference Committee No. 2—no report.

Fifth District Councillor—Mark S. Dougherty, Jr., Atlanta—Reference Committee No. 2—See page 273.

Fifth District Vice-Councillor—J. G. McDaniel, Atlanta—Reference Committee No. 2—no report.

Sixth District Councilor—Henry T. Tift, Macon—Reference Committee No. 2—See page 273.

Sixth District Vice-Councilor—H. G. Weaver, Macon—Reference Committee No. 2—no report.

Seventh District Councilor—D. Lloyd Wood, Dalton—Reference Committee No. 3—See page 282.

Seventh District Vice-Councilor—Ralph W. Fowler, Marietta—Reference Committee No. 3—no report.

Eighth District Councilor—Neal F. Yeomans, Waycross—Reference Committee No. 3—282.

Eighth District Vice-Councilor—James M. Hicks, Brunswick—Reference Committee No. 3—no report.

Ninth District Councilor—W. Bruce Schaefer, Toccoa—Reference Committee No. 3—See page 282.

Ninth District Vice-Councilor—Charles R. Andrews, Jr., Canton—Reference Committee No. 3—no report.

Tenth District Councilor—Harry L. Cheves, Sr., Union Point—Reference Committee No. 4—See page 294.

Tenth District Vice-Councilor—J. Victor Roule, Augusta—Reference Committee No. 4—no report.

Council of the Medical Association of Georgia, Audit and Appropriations Committee of Council, and addendum—H. L. Cheves, Union Point—Reference Committee No. 3—See page 287.

Honorary Advisory Board—Enoch Callaway, LaGrange—Reference Committee No. 5—See page 303.

Reports of Committees

Scientific Work Committee—Charles L. Prince, Savannah, Chairman—Reference Committee No. 1—See page 265.

Legislation Committee—Grady N. Coker, Canton, Chairman—Reference Committee No. 2—See page 273.

Legislation Committee Minority Report—J. D. McElroy, Atlanta—Reference Committee No. 2—See page 275.

Medical Education Committee—R. Hugh Wood, Atlanta, Chairman—Reference Committee No. 3—See page 283.

Medical Defense Committee—Marion C. Pruitt, Atlanta, Chairman—Reference Committee No. 4—See page 294.

Professional Conduct Committee—Enoch Callaway, LaGrange, Chairman—Reference Committee No. 5—See page 303.

History and Vital Statistics Committee—J. Calvin Weaver, Atlanta, Chairman—Reference Committee No. 1—See page 266.

Public Health Committee—T. A. Sappington, Thomaston, Chairman—Reference Committee No. 2—See page 275.

Maternal and Infant Welfare Committee—Peter Hydrick, College Park, Chairman—Reference Committee No. 2—See page 280.

Woman's Auxiliary Advisory Committee—Enoch Callaway, LaGrange, Chairman—Reference Committee No. 4—See page 294.

Constitution and By-Laws Committee, and Addendum—J. W. Chambers, LaGrange, Chairman—Reference Committee No. 6—See page 305.

Awards Committee—Hoke Wammock, Augusta, Chairman—Reference Committee No. 5—See page 303.

Industrial Health Committee—Duncan Shepard, Atlanta, Chairman—Reference Committee No. 1—See page 266.

Public Relations Committee—Chris J. McLoughlin, Atlanta, Chairman—Reference Committee No. 2—See page 277.

Cancer Committee—J. Elliott Scarborough, Atlanta, Chairman—Reference Committee No. 3—See page 283.

Rural Health Committee and Addendum—George T. Nicholson, Cornelia, Chairman—Reference Committee No. 4—See page 294.

Insurance Board—David R. Thomas, Jr., Augusta, Chairman—Reference Committee No. 5—See page 303.

Veterans Affairs Committee—Hartwell Joiner, Gainesville, Chairman—Reference Committee No. 1—See page 267.

Hospitals Committee—H. Ansley Seaman, Waycross, Chairman—Reference Committee No. 2—See page 278.

Medical Civil Preparedness Committee—Edgar Dunstan, Atlanta, Chairman—Reference Committee No. 3—See page 284.

A.M.E.F. Committee—John L. Chandler, Jr., Augusta, Chairman—Reference Committee No. 4—See page 295.

Blood Banks Committee—J. C. Thoroughman, Atlanta, Chairman—Reference Committee No. 1—See page 267.

Abner Wellborn Calhoun Lectureship Committee—Glenville Giddings, Atlanta, Chairman—Reference Committee No. 2—See page 279.

Chronic Illness Committee—L. Minor Blackford, Atlanta, Chairman—Reference Committee No. 4—See page 296.

Crawford W. Long Memorial Committee—Lester Rumble, Jr., Atlanta, Chairman—Reference Committee No. 4—See page 296.

Mental Health Committee—J. R. Shannon Mays, Macon, Chairman—Reference Committee No. 1—See page 267.

Liaison Advisory Board to the Georgia Society for Crippled Children—J. C. Hughston, Columbus, Chairman—Reference Committee No. 2—See page 279.

Eugene Talmadge Memorial Hospital Study Committee—Lester Rumble, Jr., Atlanta, Chairman—Reference Committee No. 3—See page 284.

Advisory Committee on the Eugene Talmadge Memorial Hospital—J. C. Metts, Savannah, Chairman—Reference Committee No. 3—See page 287.

State Advisory Committee to the Selective Service System—Cyrus W. Strickler, Jr., Atlanta, Chairman—Reference Committee No. 2—See page 279.

Journal of the Medical Association of Georgia—Edgar Woody, Jr., Editor, and Miss Frances H. Porcher, Managing Editor, Atlanta—Reference Committee No. 1—See page 269.

Executive Secretary—Mr. Milton D. Krueger and Mr. John F. Kiser, Atlanta—Reference Committee No. 4—See page 297.

Special Reports

Woman's Auxiliary to the Medical Association of Georgia, and Addendum—Mrs. Shelley C. Davis, Atlanta, President—Reference Committee No. 1—See page 270.

Better Health Council, and Addendum—Mrs. Bruce Schaefer, Toccoa, President—Reference Committee No. 4—See page 297.

Speaker Goodwin then stated that the next order of business was nominations for General Practitioner of the Year. The Chair asked for nominations from the floor. The Speaker indicated the candidates so nominated were to be voted on immediately following nominations, and the Speaker instructed the Secretary to record the voting on secret ballot so that the action would constitute the official House of Delegates election of the Georgia General Practitioner of the Year. The Speaker appointed William Harbin, Grady N. Coker, and Harold P. McDonald as a Tellers Committee to count the secret ballots after nominations were received.

George T. Nicholson, Cornelia, nominated C. L. Ayers, Toccoa. His nomination was made in behalf of the Ninth District Medical Society where Dr. Ayers was unanimously nominated for this honor. It was then duly moved and seconded that the nominations be closed. The Speaker instructed the Secretary of the Association to cast a ballot for the House of Delegates as a whole, and Dr. Ayers was elected the Georgia General Practitioner of the Year.

The Speaker then called on the Chairman of Council, H. L. Cheves, Union Point, to present three names selected by a committee of Council as nominees for the 1955 recipient of the Hardman Award. This award, established by former Georgia governor and physician, Lamartine G. Hardman, was to be presented formally at an Association General Business meeting Wednesday, May 4, at 10:30 a.m. in the Crystal Room, Bon Air Hotel. The candidates selected by the committee of Council were to be voted on immediately at this session so that the action would constitute the official House of Delegates election of the 1955 recipient of the Hardman Award. The Speaker instructed the Secretary to record the voting on a secret ballot. The Chairman of Council, Harry L. Cheves, presented the following three names as selected by the Council committee: (1) V. P. Sydenstricker, Augusta; (2) Enoch Callaway, LaGrange; and (3) Kenneth S. Hunt, Griffin. Results of the balloting were announced, and V. P. Sydenstricker, of Augusta, was elected by the House of Delegates to receive the 1955 Hardman Award.

The Speaker then called for unfinished business and asked the Association Secretary if there were any such matters of business so designated.

Secretary Poer brought up the changes made last year

in the Constitution. These changes concerned Article VI, Section 2; Article IX, Section 1; Article IX, Section 3; Article X and Article XI.

Allen H. Bunce, Atlanta, at this time rose to make a parliamentary inquiry. His point of order questioned the authority of the House of Delegates in adopting a change in the Constitution and By-Laws constituting a second reading which had not first been considered by a reference committee of *this* House of Delegates. Dr. Bunce recommended that these changes in the Constitution be referred to Reference Committee No. 6 and that these changes, after coming out of Reference Committee No. 6, be voted on by the House of Delegates at their second session. The motion was seconded and passed, and the changes in the Constitution and By-Laws were referred to reference committee No. 6. See page 316.

The Speaker then called for new business. He instructed the members of the House of Delegates that resolutions might be introduced at that time. He further stated that on completion of the reading of a resolution, the Chair would entertain no discussion of the resolution. Each resolution would merely be referred to the appropriate reference committee and discussion would be in order concerning that resolution at the second session of the House of Delegates when the reference committees reported on each resolution.

General Business Session

MONDAY, MAY 2, 1955

The General Session was called to order by President Peter B. Wright, Augusta, at 11:45.

Dr. Wright called on the Reverend Robert Strong, Pastor, First Presbyterian Church, Augusta, for the invocation.

Following the invocation, President Wright introduced the Honorable Hugh L. Hamilton, Mayor of Augusta, who delivered a brief address of welcome to the members of the Medical Association of Georgia at their 105th Annual Session.

President Wright then called on C. M. Templeton, President, Richmond County Medical Society, who welcomed the members of the Association in behalf of the Richmond County Medical Society.

The next order of business was the introduction of fraternal delegates attending this general business session.

President Wright then called on Harold P. McDonald, Atlanta, to introduce the guest speaker, Elmer Hess, of Erie, Pennsylvania, President-Elect of the American Medical Association.

Following Dr. Hess' talk, President Wright turned the Chair over to Willard R. Golsan, First Vice-President. Dr. Golsan then called on President Peter B. Wright for his President's Address.

Dr. Golsan called upon Tellers Committee Chairman Ralph H. Chaney, Augusta, who in turn made an announcement concerning the rules of voting and the area of the ballot box.

The Chair then called for nominations from the floor for the following officers: president-elect, first vice president, second vice-president, AMA delegate (term beginning January 1, 1956), AMA alternate delegate (term beginning January 1, 1956), councilor First Dis-

Resolutions

1. Accreditation of Hospitals—Fred H. Simonton, Walker-Catoosa-Dade—Reference Committee No. 2—See page 281.
2. Honorary Membership (John R. Fowler)—Fred H. Simonton, Walker-Catoosa-Dade—Reference Committee No. 3—See page 290.
3. Oral Prescriptions—Grady N. Coker, Cherokee-Pickens—Reference Committee No. 2—See page 281.
4. Honorary Membership (Daniel C. Elkin)—B. L. Shackelford, Fulton—Reference Committee No. 3—See page 290.
5. Rheumatic Fever—Joseph C. Massee, Fulton—Reference Committee No. 4—See page 299.
6. Medical Care Commission—Charles Mulherin, Richmond—Reference Committee No. 4—See page 298.

The Speaker introduced the next order of business as special reports to the House of Delegates. The Speaker called on Charles H. Richardson, Sr., Macon, to introduce the guest speaker presenting a special report.

Dr. Richardson then introduced George F. Lull, Chicago, Secretary-General Manager of the American Medical Association. Dr. Lull delivered an address entitled, "Your AMA."

Upon completion of the address by that distinguished guest, Speaker Goodwin entertained the motion that the first session of the House of Delegates held May 1, 1955, at the Bon Air Hotel, be recessed until Tuesday afternoon, May 3, at 2:15 p.m. The motion was duly made, seconded and adopted.

trict, councilor Second District, councilor Third District, councilor Fourth District, vice-councilor First District, vice-councilor Second District, vice-councilor Third District, and vice-councilor Fourth District. Nominations were as follows:

PRESIDENT-ELECT—Hal M. Davison, Atlanta, nominated by C. K. Wall, Thomasville. Seconded by Allen H. Bunce, Atlanta; Rupert Bramblett, Cumming; David R. Thomas, Augusta; and George H. Alexander, Forsyth.

A. G. Lynch, Atlanta, nominated by John W. Turner, Atlanta. Seconded by William Bryan, Atlanta; Harold McDonald, Atlanta; and W. A. Selman, Atlanta.

FIRST VICE-PRESIDENT—R. C. McGahee, Augusta, nominated by Thomas Goodwin, Augusta, and duly seconded.

SECOND VICE-PRESIDENT—Stephen W. Brown, Augusta, nominated by David R. Thomas, Augusta, and duly seconded.

AMA DELEGATE—(Term beginning January 1, 1956)—C. H. Richardson, Sr., Macon, nominated by W. A. Selman, Atlanta. Seconded by Spencer A. Kirkland, Atlanta; W. F. Battey, Augusta; and John W. Turner, Atlanta.

AMA ALTERNATE DELEGATE—(Term beginning January 1, 1956)—C. L. Ayers, Toccoa, nominated by J. B. Kay, Byron. Seconded by Spencer A. Kirkland, Atlanta.

COUNCILOR FIRST DISTRICT—Lee Howard, Sr., Savannah.

VICE-COUNCILOR FIRST DISTRICT—Charles T. Brown, Guyton.

COUNCILOR SECOND DISTRICT—George Dillinger, Thomasville.

VICE-COUNCILOR SECOND DISTRICT—J. Z. McDaniel, Albany.

COUNCILOR THIRD DISTRICT—W. G. Elliott, Cuthbert.

VICE-COUNCILOR THIRD DISTRICT—Luther Wolff, Columbus.

COUNCILOR FOURTH DISTRICT—J. W. Chambers, La-Grange.

VICE-COUNCILOR FOURTH DISTRICT—Clarence B. Palmer, Covington.

There being no further business at this general session, it was moved and duly seconded that the meeting be adjourned.

Second Session, House of Delegates

(Recessed)

TUESDAY, MAY 3, 1955

The House of Delegates was called to order by Speaker Goodwin at 2:30 p.m. in the Crystal Room of the Bon Air Hotel, Augusta, Georgia, May 3, 1955.

Speaker Goodwin instructed the Delegates on the proceedings to be conducted during this session of the House. He explained that each reference committee chairman would be called on to report on matters referred to his committee. Speaker Goodwin instructed the Secretary to be prepared to record the voting of the body so that any action taken might be so recorded. Lastly, Speaker Goodwin reminded the members of the House that as the legislative body of the profession in Georgia that it was their solemn responsibility to consider each motion and its ramifications before casting their vote.

Speaker Goodwin called on a member of the Credentials Committee, Willard R. Golsan, who declared a quorum present and reported the following attendance.

Attendance

BALDWIN: Wallace Gibson; BIBB: Henry H. Tift, J. B. Kay, Samuel E. Patton, Allan A. Cole, George H. Alexander, Milford B. Hatcher; BULLOCH-CANDLER-EVANS: A. J. Mooney; BURKE: J. M. Byne; CARROLL-DOUGLAS-HARALSON: R. L. Denney, C. J. VanSant; GEORGIA MEDICAL SOCIETY: John L. Elliott, W. H. Fulmer, Ruskin King; CHATTOOGA: William P. Martin; CHEROKEE-PICKENS: C. J. Roper; CLARKE-MADISON-OCONEE: J. A. Green, M. A. Hubert; COBB: W. C. Mitchell; COFFEE: Sage Harper; DECATUR-SEMINOLE: E. M. Griffin; DEKALB: W. A. Mendenhall, John T. Leslie; DOUGHERTY: Glenn E. Seymour, William M. Feild; EMANUEL: R. J. Moye; FULTON: J. D. McElroy, W. M. Moncrief, Alton V. Hallum, C. Purcell Roberts, Lester Rumble, Jr., Linton H. Bishop, Jr., Tully T. Blalock, E. D. Shanks, Jr., A. O. Linch, George W. Fuller, Joseph Rankin, B. L. Shackelford, Charles P. Yarn, H. Walker Jernigan, John W. Turner, Haywood N. Hill, E. A. Bancker, Walker L. Curtiss, Samuel A. Anderson, Irving L. Greenberg, and A. Cullen Richardson; GLYNN: J. B. Avera, Bert H. Malone; GORDON: Lewis R. Lang; HABERSHAM: J. L. Walker; HALL: W. C. McCarver, Rafe Banks; HANCOCK: George F. Green; JACKSON-BARROW: A. A. Rogers, Jr.; JEFFERSON: John J. Pilcher, Jr.; McDUFFIE: A. G. Leroy; MITCHELL: A. A. McNeill, Jr.; MORGAN: C. H. Dickens; MUSCOGEE: A. B. Conger, Robert H. Vaughan; NEWTON: F. C. Brown; OCMULGEE: Maurice F. Arnold; POLK: D. W. Schmidt; RICHMOND: Thomas W. Goodwin, David R. Thomas, Jr., George W. Wright, Stephen W. Brown, Robert C. Major; SCREVEN: Gerald B. Hogsette; SOUTH GEORGIA: F. G. Eldridge; SOUTHWEST GEORGIA: Warren C. Baxley; SPALDING: Virgil P. Williams; SUMTER: Carl P. Savage; THOMAS: Rudolph F. Bell; TIFT: C. S. Pittman, Jr.; TROUP: Charles T. Cowart, H. H. Hammet, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Fred H. Simonton; WALTON: Lynn M. Huie; WARE: W. L. Pomeroy, Leo Smith; WARREN: H. B. Cason; WAYNE: J. W. Yeomans; and WILKES: Harry L. Cheves, Sr.

County Medical Societies not represented at this second session of the House of Delegates are as follows:

ALTAMAHA, BARTOW, BEN HILL-IRWIN, BLUE RIDGE, BROOKS, CLAYTON-FAYETTE, COLQUITT, COWETA, CRISP, DOOLY, ELBERT, FLOYD, FORSYTH, FRANKLYN, GRADY, GWINNETT, HART, HOUSTON-Peach, JASPER, JENKINS, LAMAR, LAURENS, MERIWETHER-HARRIS, MONTGOMERY, RABUN, RANDOLPH-TERRELL, STEPHENS, TATTNALL, TAYLOR, TELFAIR, TOOMBS, WASHINGTON, WHITFIELD, and WORTH.

Other members of the House of Delegates in attendance were:

Peter B. Wright, H. Dawson Allen, William Harbin, Willard R. Golsan, Milford B. Hatcher, David Henry Poer, D. Lloyd Wood, W. Bruce Schaefer, George Dillinger, J. W. Chambers,

J. C. McDaniel, Mark S. Dougherty, Jr., W. G. Elliott, Grady N. Coker, William Harbin, C. H. Richardson, Sr., Spencer A. Kirkland, Ralph H. Chaney, William R. Dancy, C. L. Ayers, C. F. Holton and the Messrs. Krueger and Kiser of the headquarters staff.

In a compilation of attendance taken from the official roll, 46 county medical societies were represented by their duly elected delegates. Thirty-four county medical societies had no representatives at the second session. Of a total of 136 delegates from the respective county medical societies, the official roll showed 86 delegates present at the session.

REPORT OF REFERENCE COMMITTEE NO. 1

Ruskin King, Chairman

(The following reports as presented to this committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.) Reference Committee No. 1 met in the Penthouse at 8 a.m., May 2, 1955, with the following members in attendance: Ruskin King, chairman; Leo Smith, vice-chairman; William Harbin, R. L. Denney, Sage Harper, M. A. Hubert, A. J. Mooney, Samuel E. Patton, C. J. Roper and Milford B. Hatcher.

President

Peter B. Wright

While it has been a distinct honor to have had the opportunity of serving as president of the Medical Association of Georgia, I would like to emphasize, especially to those who will hold office in our Association in the future, that this position is fraught with many serious responsibilities which not only jeopardize the personal friendships of the president but also make costly demands on him both mentally and physically and at the same time consume very very much of his time. I have served to the best of my ability and feel that I have made only a part-payment to organized medicine to which I owe so much. All of the officers of the Medical Association of Georgia have grave responsibilities of which they should be aware before offering themselves for election. These positions are tasks, voluntarily bid for, and the time, energy and study required to properly carry out the duties must be given unstintingly.

A most unexpected turn of events during my administration was the development of differences of opinion between the Medical Association of Georgia and the Medical College of Georgia concerning the policies being developed for the operation of the new Talmadge Memorial Hospital. The Medical Association of Georgia felt that those policies were contrary to organized medicine's ethics and were in violation to the laws of Georgia relative to the corporate practice of medicine. This has been a terrific stress on me both mentally and physically as I am devoted to the Medical College of Georgia and greatly indebted to organized medicine. In an effort to obtain the opinions of the doctors of Georgia, the Council agreed to have the first called meeting of the House of Delegates ever to be held. Everyone

knows the outcome of this meeting, and I am sure that all of us sincerely hope for an amicable and satisfactory adjustment. Otherwise this could jeopardize and "set back" organized medicine a quarter of a century. Let's all pray for a happy solution!

Your president attended as many county and district meetings as he possibly could and is happy to report most favorably on the interest manifested, by the members, both organizational and scientific. There is real enthusiasm and concerted effort on the part of the constituents of these societies.

The *Journal of the Medical Association of Georgia* has continued to improve and we may well be proud of it and its staff.

The official staff of the Association have, during the past two years, been most eager to assist me in any way possible, and without them I would have been at nearly a complete loss. It became quite evident to me that our secretary (Dr. Poer) has a titanic job and also terrific responsibilities, and I have often wondered if the Association should not be a little more liberal financially and either provide for an assistant secretary or compensate him more for loss of time and travel expense or both. A doctor's loss of time cannot be accurately estimated, and I recommend that this action be taken.

Our executive secretary (Mr. Krueger) and our assistant executive secretary (Mr. Kiser) have attended many of the county and district society meetings. This has brought dividends in the form of more interest and closer relations between those societies and the Medical Association of Georgia and organized medicine. It is hoped that this program can be expanded this year.

The real value of the Woman's Auxiliary to the Medical Association of Georgia has been very much appreciated by your president. They are an invaluable adjunct to our association.

Other state medical associations have been drawn closer to us and to each other by cooperative endeavors. We foresee the possibility, through concerted action, of reducing the malpractice liability insurance rates. The Committee on Insurance is very actively participating in this.

The Committee on Scientific work has done an excellent job, and everyone is proud of the outstanding program that has been prepared for this meeting.

Dr. Hydrick has made great strides toward safeguarding maternal and infant welfare.

Dr. Joiner has presented a comprehensive study of the impingements of Veterans Administration hospitals on organized medicine. He and his committee are performing a masterful piece of work for the protection of organized medicine.

Dr. Chandler as Chairman of the AMEF Committee has made two trips to Chicago to become better versed in this endeavor and his efforts and writings are bringing in dividends—not just money but enthusiasm on the part of the doctors who, through this committee's efforts, are realizing how this program can defeat socialized medicine.

The Committee on Fraternal Delegates to Adjoining States has come into its own, and now we are realizing the necessity of conjoined efforts with our neighbors.

The other committees of the Association, although they all have not been singled out, have done a wonderful job, but they cannot rest on their laurels; they must even intensify and accelerate their activities if

organized medicine is to survive. I wish to take this opportunity of thanking each member of every committee for forwarding the principles of the Medical Association of Georgia and organized medicine.

We have established closer liaison with the State Medical Examining Board in our endeavor to eliminate "quacks." We are happy to report a favorable solution to the Workmen's Compensation Laws, to the doctors and patients alike. The American Osteopathic Association, through efforts on their part and ours, are rapidly coming into the Medical Profession on a recognized scale. We should be most grateful to Dr. Coker and his Committee on Legislation for their activities during the recent session of the Legislature of the State of Georgia and gaining so much for the Medical Association of Georgia. A closer relationship between the Association and the Governor of the State of Georgia is most essential, and I have no doubt that this committee will secure these bonds, thereby allowing us to exercise our influence within the State. While no gains were made in our efforts to have the Association consulted in regard to appointments on other state medical boards this year, I feel sure that this committee will be able to accomplish more on this problem in the year to come.

Under the most able guidance of Dr. Chambers, the Committee on Constitution and By-Laws has done a magnificent job of revision, and many years should elapse before any other major change is necessary.

Dr. Thomas has been untiring in his efforts to "set the sails" of the Insurance Board on the right course, and success is on the horizon. Medical care and hospital insurance we believe to be essential and a democratic (Georgia) plan is being worked out by his committee. Dr. Thomas and his committee deserve our most hearty appreciation.

Dr. Nicholson, Chairman of the Rural Health Committee, is doing an excellent job, and his endeavors now lead to greater things than were originally planned.

The Public Relations Committee with Dr. McLoughlin as Chairman have continued their efforts and are producing favorable results.

The experience of being president of the MAG has been enlightening and gratifying, and I hope that my efforts have done some permanent good.

Reference Committee recommendation—Committee No. 1 approved the President's Report with the exception of its comments relating to salary increases. We respectfully refer this matter to the Council for consideration. The presidential comments alluded to only a few of the many problems which have arisen during his administration. If his term of office has been more enlightening and gratifying than purely pleasurable, it is due in large part to the fact that he has attempted in every way possible to be fair, impartial, and conscientious in the discharge of his duties. He has avoided no issues, and, if he has failed to offer a solution to all of our problems, he is certainly not alone in his dilemma. We commend Peter Wright for his faithful and time consuming application to the duties of his office. We can only express the hope that future friction in our group will find us with such an able leader to bring out of them a united front. Mr. Speaker, I move that this report be accepted.

House of Delegates action—Recommended adoption of the President's Report as presented by the reference committee which was moved, seconded and adopted.

First District Councilor

Lee Howard

The regular Spring Meeting of the First District Society met at 3:00 P. M. May 26th, 1954, at the Forest

Heights Country Club, Statesboro, with Samuel F. Rosen, president, presiding.

Mr. John Kiser attended this meeting, and you probably have his impressions. There were five scientific papers with discussions and two five minute case reports.

At the business meeting, John Elliott, Savannah, was elected president-elect and W. G. Simmons, Sylvania, vice-president-elect; Ralph Bowden, Savannah, alternate to the Insurance Board. John Elliott, Savannah, was reappointed to the Insurance Board.

The Spring Meeting in Statesboro, March 18th 1953, having proven much the best attended meeting for over 10 years, and the 1954 meeting, having had an even better attendance and program, attendance 120, Lee Howard, Sr., recommended a change in the By-Laws so as to have one meeting a year in Statesboro. This was in the form of a motion and passed.

Statesboro is the geographical center of the First District, and the last two meetings seem to prove it to be the logical place for the annual meeting.

Your councilor has been working toward the objective to organize the district into four major societies. The consolidation proposed would eliminate the Liberty-Long-McIntosh Society that has only two members. These members would affiliate with the nearest society or become members-at-large. The Screven, Burke and Jenkins societies should be merged into one society with an appropriate name. These three societies have held joint meetings for the past several years and are also geographically adherent.

On February 7th, 1955, your councilor attended a meeting of the Emanuel County Society in Swainsboro. Five out of the eight members were present, and there were also one or two members from adjacent counties, Treutlen and Burke. It was unanimously voted, after discussion, that the Emanuel County Society, which includes a member from Treutlen County, join with the Bulloch-Candler-Evans Society.

On February 11th, 1955, the councilor attended the regular meeting of the Toombs County Society in Vidalia with about 12 members present, including members from Tattnall and Montgomery Counties. It was the feeling of the members present that physicians from these three counties were already holding joint meetings and should form a single society in Toombs County that would eliminate societies in Tattnall and Montgomery Counties.

With the one or two doctors in Bryan and Effingham Counties meeting with the Chatham County society, as has been their custom, this would complete a four society plan.

The MAG membership for 1954 showed a slight increase, six, over the 1953 figure. The AMA membership also increased by six.

There is and has been a critical need for rural physicians in the areas represented by Liberty-Long and McIntosh Counties. There is also a continuous need for at least two physicians in Effingham County.

C. T. Brown, vice-councilor, attended the Tri-County Meeting in Statesboro, February 10th, and gave them the information that the Emanuel County group had voted to consolidate with the Tri-County group.

They presented no problems for our consideration but voted that the councilor use his influence to remove the role of the osteopath group from that of cultists to

a more elevated group. This society has 21 members and meets monthly except during May, June, July and August.

First District Membership

Counties	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
Bulloch-Candler-Evans	20	15	19	15
Burke	9	8	10	9
Georgia Medical Society	135	118	135	114
Emanuel	8	5	5	5
Jenkins	3	3	3	3
Montgomery	3	2	3	2
Screven	5	5	5	5
Tattnall	7	3	7	3
Toombs	10	10	7	7
Tri Liberty-Long-McIntosh	2	2	2	2
Total	202	171	196	165

First District Vice-Councilor

Charles T. Brown

At the request of First District Councilor, Lee Howard, I visited the Bulloch-Candler-Evans Medical Society on Tuesday evening February 8th, 1955, at the Country Club, Statesboro. The meeting was devoted to a general discussion of hospital insurance as regards the Bulloch County Hospital. The meeting was fairly well attended and was climaxed by a very enjoyable social hour. By authority of Dr. Howard, this group was informed of the fact that the Emanuel County Medical Society had voted unanimously to consolidate with the Bulloch-Candler-Evans Society. After a general discussion, no problems were presented for the consideration of the MAG Session in May 1955. It was the opinion of those present however that the status of the osteopath group be given more consideration by physicians at large. Your vice councilor of the First District has attended all meetings of the Council during the past year with the exception of one.

Reference Committee recommendation—The Report of the First District Councilor is approved. We congratulate the councilor on his efforts toward the merging of smaller county units with adjoining larger ones. The advantages of such mergers appear obvious. The Report of the First District Vice-Councilor is approved, and we congratulate him on his interest and activities in the First District.

House of Delegates action—Recommended adoption of the First District Councilor and Vice-Councilor's Report as presented by the reference committee which was moved, seconded, and adopted.

Second District Councilor

George R. Dillinger

Membership in the Second District remains essentially the same as in 1953. There was a loss of one MAG member and a gain of three AMA members in 1954. There were 166 MAG members and 110 paid up AMA members.

Two counties, Brooks and Grady, have very inactive medical societies that seldom meet. The councilor has approached individuals in both societies offering help with programs and in working out their problems.

The other county societies of the district are meeting regularly, and showing improvement in their activities. Dougherty and Thomas Counties are the only ones who regularly notify the councilor of meetings.

Regular visitation by the MAG executive secretary or assistant would be very beneficial.

Second District Membership

Counties	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
Brooks	4	4	5	5
Colquitt	17	11	18	11
Decatur-Seminole	15	13	17	15
Dougherty	40	20	38	16
Grady	8	5	8	2
Mitchell	13	8	12	8
Thomas	35	28	33	27
Tift	13	6	15	8
Tri Calhoun-Early-Miller	15	11	14	10
Worth	6	4	7	5
Total	166	110	167	107

Reference Committee recommendation—We approve the Report of the Councilor from the Second District and commend him for his good work. Vice-Councilor from the Second District submitted no report.

House of Delegates action—Recommended adoption of the Second District Councilor's report as presented by the reference committee which was moved, seconded and adopted.

Third District Councilor

W. G. Elliott

There are 11 medical societies in the Third District. Six of these are very active. The Muscogee County Medical Society, the largest in the district is very active. They have very good programs monthly, except during the summer months. They publish a very good monthly bulletin. They held four medical forums in conjunction with the *Ledger-Enquirer* newspapers in 1954, and are having five forums in 1955. The Muscogee society cooperates well with the medical staff at Fort Benning, and one of the regular monthly meetings each year is held at Fort Benning in conjunction with the Fort Benning Medical Staff.

The Sumter County Society is active and holds good monthly meetings most of the months during the year.

The Houston-Peach Society has only two members. Most of the physicians in Houston-Peach Counties belong to Bibb County Society and attend meetings there.

The Macon County Society has only three members. Some of the physicians in Macon County belong to the Sumter County Society.

The Wilcox County Society is inactive at the present time.

The Ben Hill-Irwin Society and the Randolph-Terrell Medical Society have about four meetings during the year.

I have been unable to get any information concerning the activities of the other societies in the district for the year.

The Medical Association of Georgia members from the Third District December 31, 1953, were 177, and December 31, 1954, were 187, showing an increase of 10 members.

The American Medical Association members December 31, 1953, were 145, and December 31, 1954, were 146, showing an increase of one member.

We have two district society meetings yearly. The last one was held in November 1954 and was well attended and a very good program given.

The next meeting will be in May in Columbus in conjunction with the meeting of the Georgia Tuberculosis Association.

Third District Membership

Counties	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
Ben Hill-Irwin	10	8	13	10
Crisp	11	—	12	10
Dooley	6	6	5	5
Houston-Peach	2	2	2	2
Macon	3	2	3	2
Muscogee	98	87	92	81
Ocmulgee	12	10	8	6
Randolph-Terrell	15	10	14	9
Sumter	20	17	20	16
Taylor	5	4	5	4
Turner	—	—	—	—
Wilcox	5	—	3	—
Total	187	146	177	145

Reference Committee recommendation—The report of the councilor is approved, and the councilor is congratulated. It is urged that the matter of dividing the organization into councilor districts rather than congressional districts be expedited. The vice-councilor submitted no report.

House of Delegates action—Recommended adoption of the Third District Councilor's report as presented by the reference committee which was moved, seconded, and adopted.

Scientific Work Committee

Charles L. Prince, Chairman

The Scientific Work Committee met in Macon during the last Annual Session of the Medical Association of Georgia, on May 5, 1954, for organizational purposes.

The next meeting of the Scientific Work Committee was held in Augusta on July 11, 1954.

At this meeting, it was decided to start the annual scientific session at 2:15 p.m. on Sunday, rather than Monday morning. It was also decided to end all scientific sessions by Tuesday afternoon and have only short business sessions on Wednesday morning. This would enable those finding it necessary to return to their practices on Wednesday to attend the entire scientific section and lose only two actual days' work from their offices. In this respect, it was decided to set the social hour, president's dinner and ball for Tuesday evening. The time of the first House of Delegates meeting was changed from the usual early Sunday afternoon to 5-7 p. m., allowing more members of the House of Delegates to arrive in time for this meeting.

The other main change adopted by the Scientific Work Committee was the decision to hold a "General Practice Day" all day Monday at the General Session. The General Session for this entire day is planned to be one of varied topics of exceptional interest to the general practitioner. The various specialty groups will meet separately as usual, each supplying its own guest speaker.

Subsequent meetings of the program committee chairmen were held to effect these details.

Reference Committee recommendation—The reference committee commends the change in the hours for the beginning of the House of Delegates meeting on Sunday, so as not to conflict with the scientific sessions. The eliminations of conflicting meetings should be accomplished wherever possible. The committee is congratulated on this year's fine program. While we recognize the overall authority of the Scientific Work Committee to arrange and designate these programs as they see fit, we feel that it should point out that at the 1954 Annual Session the appropriate reference committee opposed the recommendation with respect to one day being set aside on the program of the Annual Session for general practitioners. This opposition was supported by the House of Delegates. The committee recommends that Monday and Tuesday of

the Annual Session should be designated as General Scientific Days.

House of Delegates action—George Alexander, of Forsyth, was recognized and read the following letter dated May 3, 1955, and addressed to Charles L. Prince, Chairman, Scientific Work Committee, Medical Association of Georgia.

"On behalf of the Georgia Academy of General Practice, I would like to take this opportunity to express our appreciation for the excellent program presented here at the 105th Annual Session of the Medical Association of Georgia.

"I have heard considerable favorable comment from members of the Academy as well as others concerning the General Session or 'GP Day' program on Monday, May 2. This program was extremely well planned and the speakers were excellent.

"By official vote of the Board of Directors of the Academy at a meeting held at the conclusion of the program Monday, it was recommended that this type 'GP Day' program be continued at future sessions and we hope that your committee will give earnest consideration to this recommendation."

This letter was signed George H. Alexander, President, Georgia Academy of General Practice.

Secretary Poer then read the report of the Reference Committee from the 1954 Macon Annual Session which clarified their recommendation concerning the General Session or "GP Day."

(1954 House of Delegates action—"Request deletion of the second recommendation in regard to one day being set aside on the program of the Annual Session for General Practitioners since this matter was covered adequately in the Report of the Secretary-Treasurer." . . . In discussion of this matter in the 1954 House of Delegates action on the Secretary-Treasurer's Report it was brought out that this decision is up to the Scientific Work Committee . . .)

John W. Turner, Atlanta, was recognized and spoke in favor of continuing the general session or "GP Day" as it had been planned at this session.

Fred W. Simonton, Chickamauga, was recognized and also spoke in favor of the General Session or "GP Day" type of program for future Annual Sessions of the Association.

A substitute motion was then made by George H. Alexander and seconded by John W. Turner to the effect that "GP Day" be continued as a part of the Annual Session Program of the Medical Association of Georgia.

The Speaker called for a vote and it was unanimously approved that "GP Day" be continued.

The reference committee recommendation was accepted, with the exception of the part of it in conflict with the vote to continue "GP Day" as held at this Annual Session.

History and Vital Statistics Committee

J. Calvin Weaver, Chairman

Since my last report in 1954, I have put in a great deal of work in research on the medical history of Georgia and am glad to say that I have made very satisfactory progress.

I have completed the section on Georgia as a Province and am well on the way to covering Georgia as a State, as I have now reached the pre-Civil War period. Everyday I am adding to what has already been accomplished. I have recently completed the story of Bibb County and Macon, which includes the history of the old Eclectic Reform Medical School in Macon, which was first started in Forsyth, Georgia.

At present I am working on Richmond County and Augusta and have practically completed the history of the University of Georgia Medical College in Augusta, which of course includes sketches of a good many of the doctors who practiced in Augusta. I have numerous odds and ends that will have to be woven into this story.

I also have good sketches of several counties that will give us a good deal of light on the doctors in those counties.

Just when this undertaking is going to be finished is impossible for me to say, as new material is coming in everyday from various sources that I have contacted, and I find that steady work on this medical history has been very hard on my eyes. I cannot work as long hours

at it as I would like, especially since I am still practicing medicine, and I do not have a great deal of time to put on it.

Reference Committee recommendation—The report of this committee is approved and the committee is commended for its continuing good work. It is suggested that anyone having information of interest to the History and Vital Statistics Committee send this to Chairman J. Calvin Weaver. We are debtors in one way or another to all physicians, great and small, who have preceded us in this great tradition. We need constantly to be kept aware of this. It should be our hope and our prayer that we shall be as greatly respected in our generation as they were in theirs. To this committee, and to Dr. Weaver in particular, we propose not mere commendation, but heartfelt gratitude for their efforts in bringing to life men of medicine of yesterday.

House of Delegates action—Recommended adoption of the History and Vital Statistics Committee report as presented by the reference committee which was moved, seconded, and adopted.

Industrial Health Committee

Duncan Shepard, Chairman

The committee has received, considered and answered numerous questionnaires during the past year from the American Medical Association, from the Council on Industrial Health and from the Industrial Medical Association; these questionnaires and the accompanying information were quite informative and helped keep the committee abreast of industrial health problems.

The committee was represented at the Fifteenth Annual Congress on Industrial Health held at Washington, D. C., January 23-26 by two members of the committee, Dr. Allen M. Collinsworth and Dr. Duncan Shepard. The theme of the meeting was the Whole Man in Relation to his Environment. One of the high lights of the meeting was a day-long discussion of compensation laws as administered by the various states, and the problems pertaining to compensation cases. The discussion was led by a representative of the Committee on Trauma of the American College of Surgeons, a member of the American Bar Association, representatives of labor, and others interested in compensation insurance. An interesting proposal was made to establish panels of specialists throughout the various states to which difficult cases could be referred for evaluation of disability and for recommendations as to further treatment, with the patient's being sent back to the doctor under whose care he had been; no action was taken on this proposal, and further study was to be conducted on its feasibility. Another informative session was a meeting of the chairmen of the Committees on Industrial Health from the various states, at which the chairmen discussed their own local problems together.

The Sub-Committee on Compensation Insurance of the Committee on Industrial Health was established during the past year, and liaison made with the Medical Committee of the Atlanta Casualty Insurance Claim Managers Council. This latter group was quite pleased to have a readily available liaison with the Medical Association of Georgia, and the sub-committee stands ready at any time to discuss with the Claims Manager any recurrent problems which they have with members of our Association.

Reference Committee recommendation—We approve the report of this committee, and commend them for their good work.

House of Delegates action—Recommended adoption of the Industrial Health Committee Report as presented by the reference committee which was moved, seconded, and adopted.

Veterans' Affairs Committee

Hartwell Joiner, Chairman

We have continued our program of indoctrinating physicians of the facts about the V.A. care of Vets with non-service connected disability. Several county medical societies have had reports.

There was one meeting in an open-forum with the State Legion Commander which apparently was a healthy meeting.

One meeting jointly with chairmen from other state V.A. Affairs Committees and the A.M.A. Chairman of that committee in which reports of progress from all states were discussed and summarized and then a cooperative plan was outlined for the ensuing year. A report of these recommendations has been mailed to the secretary of the president-elect of the Medical Association of Georgia.

We recommend that the program be continued with even more vigor; that the committee have a regular time for reporting all progress and the affairs of this committee to the *Journal* at least once every quarter.

We advocate active liaison between the Veteran's Administration and M.A.G. through this committee.

We advocate now going to the public with facts and informing them of the true situation, warning them of the dangers that lie ahead of the present program as administered.

Reference Committee recommendation—We recommend acceptance of this report and commend the committee for its interests and activities in veterans affairs. We further recommend that regular space in the *Journal* be devoted to the work of this committee, and that a more specific report be submitted for action at the meeting of the House of Delegates in 1956.

House of Delegates action—Recommended adoption of the Veterans' Affairs Committee Report as presented by the reference committee which was moved, seconded, and adopted.

Blood Banks Committee

J. C. Thoroughman, Chairman

The Blood Banks Committee takes pleasure in submitting the following report for the year 1954-1955.

Minimal Standards for Blood Banks: The sub-committee appointed to recommend minimal standards for blood banks has submitted a detailed and painstaking report which is now under consideration by this committee. After adoption it will be submitted to the Medical Association of Georgia and to cooperating agencies for approval and implementation. Adoption of minimal standards for blood banks should go forward to promote safeguards and standards throughout the state. This committee wishes to record its appreciation of the work of the sub-committee: G. Darrell Ayer, Chairman, W. K. Sharp, Jr., Mr. John Ward, Frederick H. Thompson, Mrs. Betty Devon, Miss Willard Jurney.

District Organization: In the event of civil or military disaster it would be difficult for this committee to efficiently mobilize the blood resources of the State from a central point. It is therefore recommended that the following members be designated to act as liaison district representatives of the committee for the purpose of mobilization of the blood banks in their district in event of emergency: Charles H. Watt, Jr., Thomasville, John H. Robinson, III, Americus, Charles E. Holloway, Atlanta, T. G. Peacock, Milledgeville, Evelyn Stephenson, Rome, Joe Mercer, Brunswick, M. D. Pittard, Toccoa.

Civil Defense: A representative of this committee has met with Civil Defense authorities on a State level

to recommend plans for acquiring and distributing emergency supplies of plasma expanders by the State Civil Defense authorities. Representatives of the committee have met with the American Red Cross officers in consideration of a recommendation to the National Red Cross of a plan to rotate blood collection bottles which are now in storage in order to insure fresh stocks. A representative of this committee has appeared before a meeting of the State Civil Defense group and reported on the status of civil defense planning on blood and blood substitutes.

Articles: The committee has encouraged the preparation of two articles to be submitted to the *Journal of the Medical Association of Georgia*, one dealing with the hazards and safeguards of blood transfusions and the other dealing with the responsibility of physicians, hospitals and blood banks in the civil defense blood program.

Georgia Chapter of the American Association of Blood Banks: Your committee, with the approval of the officers of the Medical Association of Georgia, has encouraged and assisted in efforts to organize a Georgia Chapter of this national association, believing that it would encourage and serve the interests of blood banks throughout the state.

Your committee wishes to thank the officers and staff of the Medical Association of Georgia for their cooperation and to express appreciation to the Fulton County Medical Society for the privilege of meeting in their building.

Reference Committee recommendation—We approve the report of the Blood Banks Committee and feel that they have done an excellent job.

House of Delegates action—Recommended adoption of the Blood Banks Committee report as presented by the reference committee which was moved, seconded and adopted.

Mental Health Committee

J. R. Shannon Mays, Chairman

This committee was initially organized January 1954 and consisted of J. R. Shannon Mays, Chairman, Guy Rice, Paul Schroeder, Paul Scoggins, R. D. Walters, Gibson K. Cornwell and Thomas G. Peacock. The first meeting was on the 7th of March 1954 at which the more important mental health needs of the State were studied and some recommendations were made. Due to the immensity of the problem the committee felt it could best serve its function as a study and planning group rather than an action group.

The same committee in its entirety was reappointed by the new president in May 1954. Fortunately for our small committee an opportunity soon presented itself for a pooling of our strength and interest with the Georgia Association for Mental Health. This resulted in the formation of a Committee of Psychiatrists of which the chairman of the MAG Mental Health Committee was made chairman. Thirty-eight of the leading psychiatrists in the State were active members of the committee and contributed generously of their time and thought to its proceedings. The following is the final report of this committee which was forwarded to the Sanitarium Sub-Committee of the General Assembly with the request that its recommendations be enacted into law. In November 1954 the chairman and several members of the committee testified before a sub-committee of the General Assembly for several hours in an effort to persuade them to approve our recommendations. The Legislative Committee was cordial, interested,

understanding and in their final report to the General Assembly approved all of the recommendations of the Committee of Psychiatrists.

The following recommendations and resolutions were adopted by the Committee of Psychiatrists of the Georgia Mental Health Association for presentation to the Sanitarium Sub-Committee of the State Legislature:

(1) It was recommended that the State Legislature consider the passage of the Model Commitment Law as promulgated by the United States Public Health Service in an act entitled "A Draft Act Governing Hospitalization of the Mentally Ill, as revised September 1952"—with the minimum necessary changes required to make it applicable to the State of Georgia. Copies of this act should be made available to the Legislative Sub-Committee.

(2) A resolution was passed to the effect that the Legislature be advised that the sexual deviant should be considered a person who is emotionally and medically ill; and, should he be convicted of a sexual offense, it is recommended that he be detained in the State Hospital by due process of law for an indeterminate period or until the hospital staff and medical superintendent feel he has sufficiently recovered to warrant his release. This policy of mandatory State Hospital detention would not apply to those convicted deviants with mild or first offenses whom the local courts decide to place on probation.

(3) It was resolved that the committee felt the procedure by which a patient—or his relatives—"appeal" from commitment to the State Hospital is subject to question and examination by the Legislature.

(4) Recommended approval of the \$2.75 per patient per diem rate at the Milledgeville State Hospital as recommended by the Medical Superintendent.

(5) Recommended that the report of the Southern Regional Education Board and the Dean's Committee (Hugh Wood, Hervey Cleckley, Edgar Pund, Carl Whitaker, Shannon Mays) be endorsed and sponsored by our committee. The reports mentioned recommended that \$75,000.00 per annum be allocated to the Milledgeville State Hospital for the establishment and maintenance of an intensive treatment team to be used in research, training of psychiatric residents and treatment of selected patients. It was further recommended in these two reports that after this goal is accomplished there should be an integration of the Psychiatric Residency Training Program with similar programs in Emory Medical School and the Medical College of Georgia. (For details, see Dean's Report on Integration of Psychiatric Residency Training Programs.)

(6) It was resolved that this committee endorse and sponsor the State Health Department's plan for Community Health Clinics and Child Guidance Centers as presented by Dr. Guy Rice to the Juvenile Delinquency Commission of the State Legislature.

The chairman of the Mental Health Committee also served as secretary of the Dean's Committee and a report of this committee is as follows. This report was adopted by the Legislative Sub-Committee in its entirety.

The Dean's Committee of the Georgia Association for Mental Health met at the Milledgeville State Hospital on October the 23rd, 1954 at 10:00 a. m.

The following members constituted the committee: Hugh Wood, Dean of Emory Medical School; Carl Whitaker, Professor of Psychiatry, Emory Medical School; Edgar Pund, President, Medical College of

Georgia; Hervey Cleckley, Professor of Psychiatry, Medical College of Georgia; Thomas G. Peacock, Superintendent, Milledgeville State Hospital; and J. R. Shannon Mays, Chairman Mental Health Committee, Medical Association of Georgia.

The committee discussed several problems dealing with personnel, administration and medical services of the Milledgeville State Hospital but *officially* made only the two following recommendations:

(1) Recommended that \$75,000.00 per annum be allocated to the Milledgeville State Hospital for the establishment and maintenance of an Intensive Treatment Team to be used in research, training of psychiatric residents and treatment of selected patients. The team will consist of a psychiatrist, a clinical psychologist, a psychiatric social worker and, if funds are available, a neuropathologist. The psychiatrist should be exceptionally well trained and have experience in teaching and research. He will be given a professorial assignment on the faculty of both medical schools.

(2) After the Psychiatric Residency Training Program at the State Hospital gets under way it will be functionally integrated with similar training programs at Emory Medical School and the Medical College of Georgia. Residents will rotate through all three training centers, thus assuring them of a wide variety of clinical and theoretical experience.

This integrated program will make advanced psychiatric training of unexcelled quality available to Georgia physicians. It is a well recognized observation that physicians tend to locate and practice their specialty in the area where they receive their post-graduate training. It is anticipated that a large number of the physicians completing this training will remain in the State and enter the private practice of psychiatry or join the Psychiatric Staff of the Milledgeville State Hospital or the State Public Health Service.

At the last meeting of the Committee of Psychiatrists in October 1954 the group organized itself permanently as the Georgia Psychiatric Society. The primary function will be to serve as a planning and action group for the promotion of better mental health.

The chairman attended a meeting of chairmen of the various State Mental Health Committees at AMA headquarters in Chicago September the 17th and 18th, 1954. Thirty-eight state committees were represented. The theme of the meeting was the discussion of methods of gaining a more effective integration of the techniques of psychiatry with general medical practice and the Mental Health program by which the constituent state medical association could achieve this objective. Though no sure-fire solution for these complex problems was discovered we all felt we gained many new ideas and the time was well spent.

The chairman of this committee met twice with the MAG Insurance Committee and requested them to study Blue Cross—Blue Shield and other medical service plans to determine ways by which these plans could provide for treatment of mental and emotional illnesses for a total of not more than 21 days hospitalization per annum. Only the brief, intensive treatment of moderately severe cases by qualified psychiatrists would be included. The Insurance Committee did not feel the time was propitious to make this request of the insurance companies and recommended the matter be brought before them again next year.

The committee recommended the establishment of

psychiatric departments or services in general hospitals where trained psychiatric personnel is available. It was felt that general hospitals without psychiatric personnel should have provision for at least one soundproof and secure room to house emergency cases of acutely insane persons awaiting commitment to mental institutions.

The chairman also served as a member of the Georgia Committee for Mental Health, Training and Research of the Southern Governor's Association. The present facilities were studied and tabulated and recommendations for future needs were made.

It is felt that much could be gained by a closer and more dynamic working relationship with the chairman of the Mental Health Committee of the Woman's Auxiliary to the MAG. They asked for our help and suggestions this year, but we were so involved in preparing and introducing new legislation in the General Assembly that we let them down.

Reference Committee recommendation—We approve the Report of the Mental Health Committee and commend them for the fine work being done. It is suggested that more specific study be given the problem of the alcoholic patient.

House of Delegates action—Recommended adoption of the Mental Health Committee Report as presented by the reference committee, which was moved, seconded, and adopted.

The Journal

Edgar Woody, Jr., Editor

**Miss Frances H. Porcher, Managing Editor
Staff and Policy**

This yearly report on the current status of the *Journal of the Medical Association of Georgia* includes four primary topics concerning the program and policies of the *Journal*: staff and policy, content, typography and format, and financial status. Certain aspects of the publication have changed considerably during the past year. The Editor and the Managing Editor submit the following report:

Edgar Woody, Jr., Atlanta, was named Editor of the *Journal* by the Council on June 6, 1954, succeeding David Henry Poer, and Miss Frances H. Porcher succeeded Mr. John F. Kiser as Managing Editor at the same time.

The Executive Committee of Council was officially delegated Publications Committee, as recommended in the report of the Associate and Managing Editors last year, facilitating final decisions regarding *Journal* policy.

It was decided at the *Journal* Conference on May 30, 1954, that Contributing Editors should continue to be chosen with geographic location and specialty taken into special consideration, and that henceforth the Contributing Editors should be appointed annually (also recommended in last year's report). The following MAG members were appointed by the Editor and approved by Council for the current year: Herbert S. Alden, Atlanta; Thomas Findley, Augusta; Charles W. Hock, Augusta; Charles S. Jones, Atlanta; Arthur M. Knight, Jr., Waycross; William H. Lippitt, Savannah; Arthur J. Merrill, Atlanta; George T. Nicholson, Cornelia; Lester Rumble, Jr., Atlanta; Peter L. Scardino, Savannah; Patrick C. Shea, Jr., Atlanta; Henry H. Tift, Macon; and Robert H. Vaughan, Columbus.

The policy of inviting guest editors for special issues, instituted in 1953-1954, has been continued with great success. The September issue, the special Emory Issue, was edited by Ted F. Leigh, the *Journal's* regular Photography Editor. It is anticipated that several issues in

the coming year will be under the direction of other guest editors.

J. Willis Hurst, Book Editor, was called to active duty in the U. S. Navy in October 1954. Since that time the *Journal* office has taken over his duties of receiving and distributing books for review. This arrangement has worked out very satisfactorily and will probably be continued.

Recommendations:

It is recommended that henceforth the first three illustrations of average size accompanying any scientific paper be paid for by the *Journal*. This policy conforms with that of many leading medical journals.

It is further recommended that part-time secretarial help be employed to facilitate the handling of the increased load of correspondence and general typing required in the *Journal* office.

Content

The *Journal* is continuing to publish a monthly Secretary's Letter to keep doctors informed of medical and legislative activity on both state and national levels. Also continuing are the Heart and Cancer Pages sponsored by the Georgia Heart Association and the Georgia Chapter of the American Cancer Society respectively.

The "Information" section has expanded considerably. It now includes an "Announcements" division and a more informative "Personals" division. An attempt has been made to have reporters appointed in each district, but so far this has not proven productive. The personal news is now presented by districts in the hope that any lack of local news will be brought into bold relief and spur members to send in news of their own accord.

Typography and Format

Striking changes brought about in the typography and format of the *Journal* in the last two years have been maintained. A few specific improvements in format made this year include: a new cover design; the use of color on the Contents Page, the Heart Page and Cancer Page; new headline style and section markers for the "Editorials" section, "The Association" section and the "Information" section.

For the first time, this year the Roster of Membership was published separately as a supplement to the *Journal*. Also for the first time, the members were listed alphabetically as well as by county.

Advertising is now blocked in the front and back of each issue making the scientific material continuous throughout the *Journal* and thus easier to read. Feature pages are now found in approximately the same location each month—another aid to the reader in finding the information he seeks.

The *Journal* staff continues to be particularly proud of its fine cover illustrations for which Ted F. Leigh is responsible. To better utilize these illustrations, the new cover, designed by Mr. John S. McKenzie, provides a much larger area for the cover picture.

Attempts will be made during the coming year to maintain a consistent overall format while at the same time continuing to make specific changes to keep the *Journal* an attractive publication.

Financial Status

The financial status of the *Journal* at present is consistent with the pattern set during 1952-1953. In the past several months national and local advertising have shown an encouraging increase.

During the year, efforts have been made to have ad-

vertising revenue pay for monthly printing costs. Certain issues, such as the Roster Issue, Annual Session Issue and the Proceedings Issue, will always exceed current advertising revenue, but by publishing several 64 page issues a year a desirable balance is achieved.

Reference Committee recommendation—We approve the report of the Journal Editor and the Managing Editor. We feel that we have an excellent state Journal in every respect, both in content and in format, and are greatly indebted to the editorial staff for its excellent work. The recommendations contained in this report with respect to illustrations and further secretarial help are approved by this committee and referred to Council.

House of Delegates action—Recommended adoption of the report of the Journal Editor and Managing Editor as presented by the reference committee, which was moved, seconded, and adopted.

Woman's Auxiliary to the Medical Association of Georgia

Mrs. Shelley C. Davis, President

It is a pleasure to report to the Medical Association of Georgia the progress and accomplishments of its Auxiliary for the year 1954-1955.

Leadership in Community Health has been the theme of Auxiliary efforts and "Operation Doorstep" the slogan of every county medical auxiliary in the state.

Realizing that one of the greatest channels of service for the Medical Association of Georgia is in the field of promoting better relationships with the lay public for the doctors, the Auxiliary's program "Operation Doorstep" has projected into every phase of community health activity, thus again assuring the public of the sincere interest of the doctor and his family in Community Health.

Your Auxiliary has been represented at the state level meetings of all public and private health agencies during the year.

Leadership in community health began with doctors' wives *organizing hospital auxiliaries*, including the laity, for numerous new Hill Burton hospitals. *Pre-school health round-ups* for PTA's claimed many volunteer hours as did the *annual school children's audio-visual examinations*. For the fund raising drives of local *community chests*, *heart*, *muscular dystrophy*, *cancer*, *crippled children*, *multiple sclerosis*, *polio*, *cerebral palsy* and *tuberculosis*, our services were rendered in staff work to a greater degree than actual solicitation of funds. For the *rheumatism and arthritis* campaign, volunteers helped with the radio and television kick-off and telephone answering for the "telethon". For *handicapped children* study has been given to special education for them to the extent that one county auxiliary has established a scholarship to train special teachers for the *mentally retarded* and others have been instrumental in establishing special classes in public schools for the *cerebral palsied*, *deaf*, *blind* and *brain injured*. *Mass chest X-rays* by the Tuberculosis Association and *bloodmobile visits* by the Red Cross have been sponsored by Auxiliaries throughout the state. A *walking blood bank* was sponsored by yet another county auxiliary.

In order to relieve Public Health nurses of some clerical work and allow more home calls, volunteers served in *pre-natal* and *well-baby clinics*. For the *Visiting Nurses Association* there have been gifts of a hospital bed, layettes, bed linens and medical supplies and to *charity hospitals*, books, tooth paste, apparel and personal necessities as well as regular volunteer service.

Local surveys have been made of facilities for the *aged and chronically ill* while handmade articles from the homes have been sold to secure funds for them. A continuous *bandage service* is maintained for *cancer patients* as well as *gift and loan closets* and at county fairs and the Southeastern Fair, volunteers have aided public education by *staffing the cancer booths*.

Over 400 members are supplying leadership to the youth of America through the *Cub Scouts*, *Boy and Girl Scouts*, *Y.W.C.A.*, *Y.M.C.A.*, *speech schools*, *child guidance clinics* and the *U.S.O.* A liaison with the *Federated Women's Clubs*, *Junior Service League*, *Council of Churchwomen*, *PTA*, *Better Health Council of Georgia*, *American Legion* and *Veterans of Foreign Wars Auxiliaries* is maintained by doctors' wives holding official positions in these organizations.

Services for our doctors and the hospitals in which they work include *volunteer work*, both clerical and assistance to professional personnel, *raising funds for a medical library*, *sponsoring hospital gift shops* and a *rolling magazine library*, *assuming responsibility of interior decoration in newly constructed hospitals* and promoting good relationships by *entertaining hospital internes and nurses*.

Eleven *medical forums*, with our doctors as panel participants, have been planned and sponsored by your Auxiliary this year. Requests from the public for future forums attest to the success of this endeavor and the need for future programs of this nature. Surely the community health activities of the Georgia doctor's wife had wide-spread public relations and real community service.

Within the established Auxiliary program, approved by the Advisory Committee from the Medical Association of Georgia, accomplishments have been legion.

SAFETY: Since it was determined that 80 per cent of all Georgians were not familiar with the newly adopted Uniform Traffic Code of Georgia, a public information program was established. Through our work with civic and service organizations, schools, the State Highway Patrol and youth organizations, many additional towns will institute Driver Training Courses in the High Schools in 1955; in the elementary schools, a Cycle Safety Program; and for adults, promotion of the Automobile Responsibility Law and motor vehicle inspection.

CIVIL DEFENSE has claimed doctors' wives in every area for First-Aid instructors, teachers of instructors, home nursing, disaster mass feeding in city parks, Civil Defense directorships, filter center and ground observer corps personnel. Your Auxiliary has representation on the State Civil Defense Advisory Committee.

NURSE RECRUITMENT has seen great progress with 17 loans and scholarships from county auxiliaries. Future Nurse Clubs have been organized in High Schools and with the aid of the State Health Department, Georgia State Nurses Association, League of Nurse Education, Public Health Nurses Association and schools of nursing, information pertinent to nursing training has been assembled for distribution throughout Georgia and particularly through vocational councilors in the public schools. A coordinated recruitment program is finally being achieved through efforts of your Auxiliary. Twenty-six student nurses are now proteges of county auxiliaries.

LEGISLATION interest, both state and national, has

been keen particularly during the last session of the Georgia General Assembly. The wives of legislators and constitutional officers were entertained by Fulton County Auxiliary. Telegrams and letters concerning pending health legislation were sent legislators, and hope for some form of basic science law for Georgia provoked study of other state laws for protection of the public from pseudo doctors. A potent force stands ready to assist the Medical Association of Georgia in this field.

MENTAL HEALTH activities of county auxiliaries have produced four new local mental health societies. A resolution on mental health, approved by a county medical society's Advisory and Legislation Committees, was sent to the Legislature urging legislative consideration of Georgia's mental health problems. Public meetings sponsored by county auxiliaries have instigated a chain reaction of programs in many other organizations interested in prevention of juvenile delinquency and institutional care for the mentally incompetent.

RESEARCH AND ROMANCE OF MEDICINE is an Auxiliary program latent in possibilities. As in previous years, papers have again been written and placed on file that are rich with the history of medicine in Georgia, the outstanding doctors who have played a part in progress and the situations that have precipitated medical advancement in our state. It could well serve as a library of real historical value to the Medical Association of Georgia at such time as the doctors are interested in utilizing it.

TODAY'S HEALTH, the AMA publication, has been assigned to the doctors wives of the nation for circulation and distribution. The goal of a subscription from every doctor and dentist in Georgia for reception room reading material has not been reached. Although there has been an increase in subscribers, the ultimate aim cannot be accomplished without further cooperation from our doctors. Auxiliaries have provided *Today's Health* in public and school libraries, beauty and barber shops, railroad and bus stations and to private subscribers.

DOCTORS DAY is truly another public relations project. In the beginning, March 30th, anniversary of Dr. Crawford W. Long's first use of ether anesthesia, was established by Georgia doctors' wives as a day of personal tribute to their husbands. This year through tactful management, the Governor proclaimed that March 30th be set aside to honor our physicians for their tireless services to mankind, thus focusing attention on the endless and often unremunerative services of the medical profession. Department and drug stores exhibited posters in show windows and newspaper ads honoring doctors; newspaper, radio and television carried tributes also. In addition to these, the Auxiliary interested greeting card companies in making available Doctors' Day cards for grateful patients to send to their physicians. Certainly it is a worthy effort to channel public attitudes.

AMERICAN MEDICAL EDUCATION FOUNDATION will receive personal contributions amounting to \$455.00 from the Woman's Auxiliary to the Medical Association of Georgia this year following the suggestion of Dr. Peter B. Wright to support this program to save our medical schools from federal subsidization.

THE MEDICAL STUDENT LOAN FUND of the Woman's Auxiliary has had a most active year processing 10 loans totaling \$5,280.00 to students attending

the Medical College of Georgia and Emory University. There are two previous loans outstanding bringing this committee's investment in medical loans in Georgia to \$6,435.64.

With no employed staff or secretarial assistance, the burden of coordinating such an extensive program of service is a gigantic one for the officers and chairmen of the Woman's Auxiliary to the Medical Association of Georgia. To better administer the operation of the organization, a *Hand Book* setting forth basic procedures, explanations of program and projects, Constitution and By-Laws, dates, deadlines and reports has been compiled and printed. It will serve both county and state officials and is being distributed for the first time at this Convention.

Although the financial operation of the Woman's Auxiliary is not of tremendous proportions, a new *system of bookkeeping and auditing* has been adopted; *records and materials have been collected* from the homes of members over the state for temporary housing with the Fulton County Medical Society in Atlanta and *the coordination of County Auxiliary fiscal years* to coincide with the state Auxiliary is in process.

For constant and regular contact with the entire membership in the state, the *Auxiliary News* is an invaluable publication. National recognition has been accorded Georgia and the editors of the *Auxiliary News*. In addition to keeping the members informed, it has served to create interest and stimulate membership in the medical Auxiliary which now stands at 1,416 with *seven new counties organized* into three county units this year.

To the officers and members of the Medical Association of Georgia, our Advisory Committee and the employed staff in the state headquarters office, your Auxiliary is indebted for the opportunity to serve and attain the success that is a gratification at the close of a most progressive year.

Without the financial assistance of our parent organization, the Medical Association of Georgia, the *Auxiliary News* would be an impossibility; a printed Annual Report for record and reference could not be ours and the supplemental assistance for the Auxiliary President and President-Elect to attend the AMA Auxiliary Conference in Chicago is a stimulus for additional personal expenditure in order that Georgia might take its rightful place among the state auxiliaries of the nation.

As Auxiliary President, it has been a privilege and an honor to serve both the Medical Association of Georgia and its Auxiliary, to represent the wives of doctors in many presidential duties and to have the opportunity of personally meeting the members in almost every county auxiliary in the state.

To a most loyal and active Executive Board and the enthusiastic cooperation of the county auxiliaries the credit is due for this report of progress and accomplishment for the year 1954-1955.

Addendum

Your Auxiliary is indeed appreciative of this token two minutes to come before you and express our gratitude for your support and interest this year as your wives have executed a tremendous program of leadership in community health in support of you and the Medical Association of Georgia.

Our object in being an organization is to assist the medical profession and, as laymen ourselves, serve as

public relations agents to help channel public attitudes for your benefit as well as serve our own communities.

Your success is our success and we dedicate ourselves to the task of serving you, our parent organization.

We are now a big organization and would like to do even more, but as wives, we must depend upon you.

We would like to include in our fellowship every doctor's wife in Georgia, but *cannot* organize an auxiliary in any area without your consent and blessing—and so—many are still left out.

Also, we have been given a responsibility by the AMA to put its publication *Today's Health* in every doctors reception room in Georgia. It is cheaper than most magazines you buy—Will you give the Auxiliary your subscription right away?

I would like to ask you at this time to get out your Delegates Handbook and turn to the very back on page 104. May I ask you to read the report of your wife's activities even if you depend on reference committees for all the rest. It will amaze you to realize what your wife has accomplished in your interest while you have been busy with the practice of medicine.

It has been a privilege to represent your wives as Auxiliary President, and I sincerely hope that after reading the Auxiliary Annual Report, you will feel that your Auxiliary merits your continued financial and moral support.

Reference Committee recommendation—It would be impossible to praise too highly the work of the Woman's Auxiliary to the Medical Association of Georgia. The work that these ladies have done in supporting their husbands, not only in their individual problems, but in giving impetus and leadership to better health in their respective communities, is simply immeasurable. Mrs. Shelley C. Davis, President, has given splendid leadership to this organization, and her report is a most inspiring one. It is most difficult to see how we ever existed without the aid of the Woman's Auxiliary. We urge that whenever these ladies ask us for support either financial or moral, we give it to them unstintingly. We propose the acceptance of this report with a rising vote of thanks.

House of Delegates action—Recommended adoption of the Report of the Woman's Auxiliary to the Medical Association of Georgia and the Addendum to the report as presented by the reference committee, which was moved, seconded, and adopted.

The Chairman of Reference Committee No. 1 moved that the reference committee report be accepted as a whole with the exception of changes voted upon by the House of Delegates. This motion was seconded and adopted.

REPORT OF REFERENCE COMMITTEE NO. 2

Henry H. Tift, Chairman

(The following reports as presented to this committee are printed in full with the reference committees recommendation and the action pursuant to it by the House of Delegates.) Members of Reference Committee No. 2 present at the meeting were as follows: Henry H. Tift, chairman; Lee Howard, Jr., vice-chairman; H. L. Cheves, C. F. Holton, J. B. Avera, R. C. Major, C. L. Ayers, Julian Quattlebaum, and J. L. Walker.

President-Elect H. Dawson Allen, Jr.

Your president-elect has attended all meetings of the Council, as well as meetings of the Executive Committee with the exception of the meeting of September 21 which was held in Atlanta just previous to an anticipated vacation.

In August I attended the meeting of the Walker-Catoosa-Dade Medical Society which met at the farm home of Dr. Fred Simonton near Franklin, Heard County. This was a delightful meeting with barbecue on the lawn of Dr. Simonton's farm home in setting entirely inducive to conviviality, and it was an opportunity to see what a busy doctor does with his leisure time.

In September I attended the fall meeting of the Ninth District Society which met in Winder with an afternoon session of four scientific papers, a social hour at the home of Dr. Alex Russell and a banquet supper which featured barbecued chicken as can only be raised and cooked in the Ninth District of Georgia, which in addition to being cooked beyond compare, also emphasized changes of great interest to doctors in general, the contribution this district has made to the nutrition of the entire nation in its leadership and number one position in broiler production. As a loyal compatriot of the Sons of the American Revolution, I was particularly impressed with the report of two cases of stramonium poison from eating Jimson weeds, as this is perhaps the first occurrence of this condition since one of my forefathers landed at Jamestown in 1607 and mistook this plant for winter greens.

My anticipated visit to the fall meeting of the Third District in Americus was interrupted by a conflicting date of a meeting of the Fulton County Society of Neurology and Psychiatry. Since the latter was having a special program and I had committed myself to drive one of my colleagues, who was to be made an honorary member of this society, to this meeting, I could not change my plans.

Also, an anticipated trip to Douglas was interrupted by my being on a vacation.

I, of course, attended my home district society, the Sixth, which met in Macon in December. This meeting had an outstanding scientific session, a business session with the election of officers and the election of Dr. Henry Tift as my successor as councilor for this district; and as is always the case, the Bibb County Society put on a delightful dinner with dancing at the Idlehour Country Club.

In January 1955 I attended the 50th Anniversary Meeting of the Fulton County Society in Atlanta. Incoming President Shackelford reviewed the 50 years history and presented the charter members in attendance and those now living but not present. A witty and inspiring address was given by the guest speaker.

I also attended a supper given by the Legislation Committee for the House and Senate January 31.

On February 7 I attended a meeting of the Carroll-Douglas-Haralson Tri-County Society at Tallapoosa. This was a supper meeting with a business session, and I, as principal speaker, talked on our medical association, at which time I tried to make the point that the most important unit of our organization and from which all of our authority in matters of medicine stems is the county society or combined county groups; that discipline of a physician for any unethical or rather immoral practices has to be first judged at the county level, and that this followed the general court practices of our democracy whereby every misdemeanor or crime must be tried within the first jurisdiction of the offense unless the alleged offender seeks a change of venue. It is also my feeling that as only six cases of alleged misconduct have come to the attention of the Grievance Committee

within the past year that the 2,000 odd doctors, now members of our Association, are a pretty well-behaved group.

Reference Committee recommendation—The Report of the President-Elect was approved and the motion was made to commend Dr. Allen for the fine work done during the year. This motion was approved by the reference committee.

House of Delegates action—Recommended adoption of the President-Elect's Report as presented by the reference committee, which was moved, seconded, and adopted.

Fourth District Councilor

J. W. Chambers

The Fourth District continues to make progress in organized medicine. Many of the societies in this district are in the process of rewriting their Constitution and By-Laws and bringing them up to date. The county society meetings are well attended, and in general interest is good. The district society has met four times in 1954 with good programs and good attendance but not as good as it might be. This is partly due to the fact that geographically this district is quite long from north to south making travel distance a problem for some members for some meetings. At its meeting in the fall the Fourth District Society voted to reduce its number of yearly meetings to two instead of four.

There has been one professional conduct problem in this district during the year which was handled through a component society and finally resulted in the expulsion of one member. Details are available to those interested through the headquarters office and the component society.

Fourth District Membership

Counties	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
Clayton-Fayette	5	4	6	3
Coweta	18	3	18	—
Henry	1	—	1	—
Lamar	5	4	5	4
Meriwether-Harris	17	9	18	11
Newton	13	11	10	8
Spalding	33	30	32	28
Troup	41	33	40	37
Upson	20	15	20	17
Total	153	109	150	108

Reference Committee recommendation—The Fourth District Councilor's report was approved by this committee.

House of Delegates action—Recommended adoption of the Fourth District Councilor's report as presented by the reference committee, which was moved, seconded, and adopted.

Fifth District Councilor

Mark S. Dougherty, Jr.

The meeting of the Fifth District Medical Society was held on November 4, 1954, at the Academy of Medicine. Dr. Edgar Pund, of Augusta, was the guest speaker and spoke on the subject of "The Significance of Pre-Invasive Carcinoma of the Cervix During Pregnancy." A certificate of appreciation was presented to Congressman James C. Davis as an expression of appreciation for the interest he has shown in the affairs of the Fifth District Medical Society. The officers elected for the following year were: B. Hartwell Boyd, President, T. E. McGeachy, Vice-President, and J. H. Hilsman was elected Secretary and Treasurer for a period of three years. The membership of the Fifth District Medical Society has grown steadily and is higher than it has been at any time before.

Fifth District Membership

Counties	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
DeKalb	50	45	37	31
Fulton	825	636	832	595
Total	875	681	870	627

Reference Committee recommendation—This report of the Fifth District Councilor was approved by the reference committee.

House of Delegates action—Recommended adoption of the Fifth District Councilor's report as presented by the reference committee which was moved, seconded, and adopted.

Sixth District Councilor

H. Dawson Allen, Jr., and Henry H. Tift

The Sixth District Society shows a gain of 13 members in the Medical Association of Georgia and 7 members in the American Medical Association during 1954. The two regular meetings of the society were held, the April meeting in Dublin and the December meeting in Macon. Both meetings were well attended and excellent scientific programs were presented.

Henry H. Tift, of Macon, was elected councilor to fill the unexpired term of H. D. Allen, Jr., who is now a member of the Council by virtue of being president-elect of the Medical Association of Georgia. This election took place at the December meeting of the society. George Alexander invited the society to have its April meeting in Forsyth in 1955, and the invitation was unanimously accepted.

Sixth District Membership

Counties	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
Baldwin	26	11	28	11
Bibb	141	124	128	113
Hancock	4	—	3	1
Jasper	4	3	4	3
Jefferson	6	4	6	3
Laurens	23	10	19	11
Monroe (affiliated with Bibb)	2	—	4	3
Washington	13	11	14	11
Total	219	163	206	156

Reference Committee recommendation—The Sixth District Councilor's report was approved by this reference committee.

House of Delegates action—Recommended adoption of the Sixth District Councilor's report as presented by the reference committee, which was moved, seconded, and adopted.

Legislation Committee

Grady N. Coker, Chairman

For the first time in recent years, the proceedings of the Georgia General Assembly meeting in Atlanta in January and February of 1955 were kept under constant observation by representatives of the Association during the entire session. Every bill of any kind that was introduced during the session was studied with a view of finding any medical or health implications.

Three members of the Association were in the legislature this year, and a member of the headquarters office attended almost every meeting of the legislature. Copies of some 25 bills of interest to the medical profession in Georgia that were introduced during the session were kept on file in the headquarters office and a

weekly newsletter was sent out informing some 300 key men and officers in the Association on progress of these bills in the legislature.

No comprehensive health legislation was introduced due to the announcement at the beginning of the session that no additional state appropriations could be made at this session. However, when the legislature meets in January 1956 it is highly possible that money will be available for such programs as mental health, hospital care on the county level for the indigent sick and other health measures of interest both to the Association and the Georgia Department of Public Health.

Several meetings of the committee were held while the General Assembly was in session, and bills that had been introduced were considered by the committee and approved or disapproved. The headquarters office was instructed to assist in these meetings and in the following up of the action of the committee votes.

Much of the success or failure of the committee's work depended on the efforts or lack of effort of members of the Association scattered throughout the state who were contacted during the session. It was noted that considerable support was given to the committee on matters in which the Association opposed a bill that was before either house of the legislature. However, in matters which the Association sponsored or gave approval, support was not as strong, and it is hoped that in future years more support can be given to the affirmative side of the Association's legislation program and less emphasis put on the negative approach.

Most controversial of the 25 bills which were of interest to the Association were two bills which would have provided full medical practice privileges for osteopaths and naturopaths. Both of these bills, introduced in the Senate, received considerable support from certain Senators, but both were defeated by a vote of two to one. It is hoped in the future that this kind of bill can be discouraged before actual introduction.

A bill sponsored by the Association and the State Health Department which will strengthen regulations regarding midwives was passed, and this was considered a splendid achievement by both organizations. The Workmen's Compensation Law was amended to raise the maximum medical benefits from \$750 to \$1500. And a number of bills regarding lunacy trials and restoration to sanity proceedings were introduced. One of these, removing out-of-date procedures from the present law regarding lunacy trials in the Milledgeville State Hospital, was passed and made law. The Juvenile Court Act was amended to provide for psychiatric and medical care for children by juvenile courts in the State. A bill sponsored by the Association was passed which will permit the hiring of alien physicians by the two medical colleges in the State. The Hospital Authority Law was amended to allow hospital authorities to contract for services with municipalities.

Three bills, which the Association sponsored, failed to pass. Bills which would have provided for compulsory inoculation against rabies, permitted the oral prescription of certain narcotic drugs, and provided for a county tax for the care of indigent sick all failed to pass but will probably be introduced at the session next January.

Recommendations:

If the Association is ever to become an organization of considerable influence in the State for the welfare of the health of the people and the quality of medical

care in the State, real concern should be given to the operation of the Legislation Committee and to all matters of medical legislation that are brought before the General Assembly. The Association should take an active part in not only sponsoring legislation but actually writing the bills and seeing that they are introduced and passed. Improvements in the health laws of the State are badly needed in many phases such as mental health, licensing boards and hospitalization. This committee should be a year round active committee that meets periodically and prepares well in advance for all sessions of the General Assembly and should also be concerned with national legislation whenever it pertains to the medical profession.

It is recommended that the committee be divided into two committees with a co-chairman in charge of all federal legislation. Each committee could then become thoroughly familiar with its respective legislature or congress, and individual members of the two committees could be assigned specific tasks regarding proposed legislation.

It is recommended that each of these committees maintain key men throughout the state to promote medical legislation on the district and county level. The federal committee concerned with federal legislation would probably have 10 or more key men, one for each of the 10 congressional districts. The state legislation committee concerned with Georgia legislation would maintain as many key men as necessary, probably one for each of the representatives and one for each senator. It is recommended that the list of physicians of the various members of both houses of the state legislature be compiled by the headquarters office and that this list be kept on file for reference.

It is further recommended that materials and personnel as needed be made available to the committee well in advance of any session of the state legislature, and that definite programs of health legislation be worked out well in advance by the committee so that these measures may be brought to the attention of members of the General Assembly before the session begins, and so that other organizations or civic groups may approve these measures so that they may aid in promoting their passage.

It is further recommended that the state legislation committee always meet at least 60 days in advance of any meeting of the General Assembly.

It is recommended that more physicians be encouraged to run for public office.

A representative of the headquarters office recently made a trip to Tennessee on behalf of the Legislation Committee to study plans and procedures used by the Tennessee State Medical Association. Many health laws passed in Tennessee in the last four or five years and particularly laws passed at the recent session of the Tennessee legislature need to be brought to the attention of the Association and the Georgia General Assembly. Other states should be contacted throughout the year for advice and measures passed in other states should be considered for passage in Georgia.

It is specifically recommended that the following measures be considered for introduction at the January session of the Georgia General Assembly:

1. Basic science law.
2. Indigent hospitalization on the county level.
3. Oral prescription law to conform with federal law.

4. A law providing for compulsory inoculation against rabies.
5. A law giving the state examining boards the power to enjoin.
6. Comprehensive mental health legislation as regards commitment procedures, restoration to sanity procedures, mental health clinics, outpatient clinics in connection with the State Hospital, and increased funds for the general care of mentally ill persons in the State.
7. Laws relating to Blue Cross Hospitalization.
8. Prohibit use of "Dr." before practitioner's name.
9. Create advisory board regarding appointments on state medical boards.

Minority Report of the Committee on Legislation

J. D. McElroy, Atlanta

I. A report of the Committee on Legislation was drawn, submitted, and published without consultation on the part of the chairman with the other members of the committee.

II. The undersigned does not presume to speak for Dr. Aven, who is not present but who knows of this report and has discussed this issue with his alternate.

III. The undersigned specifically disagrees with that portion of the report beginning on line 12, page 47, of the *Delegates' Handbook* which reads: "It is recommended that the committee be divided into two committees with a co-chairman in charge of all federal legislation. Each committee could then become thoroughly familiar with its respective legislature or congress, and individual members of the two committees could be assigned specific tasks regarding proposed legislation." It is submitted that legislation dealing with the health of our citizens is similar to legislation in other states and on a national level. It is contended that the policies of the AMA are the policies of the constituent bodies. It is to be noted that regional conferences sponsored by the AMA have been held in this area and that these conferences have promoted a better understanding of common problems in the various states in this region. The AMA has sent representatives to this area for consultation regarding local problems. The most recent of these conferences was on October 14, 1954. A regional conference is scheduled for November 6, 1955. May it be recorded that each member of the Medical Association of Georgia Committee on Legislation receives weekly reports regarding legislation on the national level.

It is my conclusion that having too many committees, particularly wherein the delineation of duties requires hair-splitting, is not to the best interests of the MAG nor to the people whom it represents. I therefore recommend to the House of Delegates the deletion of the above quoted paragraph.

Reference Committee recommendation—The reference committee approves paragraph 1 of the Legislation Committee report. The reference committee recommends that paragraph 2 be deleted from the Legislation Committee report in compliance with the minority report. The reference committee wishes to change paragraph 3 as follows: The first sentence be changed to read, "It is recommended that the committee maintain key men throughout the state to promote medical legislation on the district and county level." The committee further recommends that sentence 2 in paragraph 3 be deleted, and that sentence 3 in paragraph 3 be changed to read: "The committee concerned with legislation would maintain as many key men as necessary, probably one for each of the representatives and for each senator." The committee

recommends that paragraph 4 of the Legislation Committee's report be approved. The committee also recommends that paragraph 5 be approved with the following change in wording: "It is further recommended that the Legislation Committee always meet at least 60 days in advance of the general assembly." The committee recommends that paragraph 6 and 7 of the Legislation Committee report be approved. The committee further recommends that paragraph 8 be approved with the following changes: 1. (Basic science law) It is recommended that this be referred back to the committee for further study. 2. (Indigent hospitalization) Was approved. 3. (Oral prescriptions) It is recommended that this be referred back to the committee for further study and consultation with the medical members of the legislature. 4. (Rabies inoculation) Approved with the following change in wording: "A law providing for compulsory inoculation of dogs against rabies." 5. (Enjoining Act), 6 (Mental health) and 7. (Blue Cross) Approved. 8. (Use of M.D.) It is recommended by this reference committee that 8 be deleted. It is recommended by this reference committee that 9. (Medical Boards) be approved.

House of Delegates action—After some discussion by Dr. Coker, Dr. Ayers, and Dr. McElroy, it was recommended that the Legislation Committee's report and the minority report as presented by the reference committee with their alteration be approved. This motion was seconded and adopted.

Public Health Committee

T. A. Sappington, Chairman

The Public Health Committee met, and it is felt that definite progress has been made in the function of this committee. The minutes of the meetings held are herewith submitted as the committee's report.

A preplanning meeting of the 1954-55 Committee on Public Health was called to order at 3 p. m., October 27, 1954, at the Academy of Medicine, Atlanta, by Chairman T. A. Sappington.

Present, in addition to Chairman Sappington, were T. F. Sellers, John Venable, Guy V. Rice, S. C. Rutland, Lester Petrie, R. C. Williams and Messrs. Milton D. Krueger and John F. Kiser, MAG Headquarters Office.

The minutes of the last two meetings of the committee were read and approved.

Mr. Krueger presented an organizational plan whereby the MAG Public Health Committee would consider all matters of public health and function largely as a screening body, and when matters referred to them involved other MAG committees this material would be turned over to the MAG committee involved.

This plan then called for the MAG Public Health Committee to screen material for the following other MAG committees: Rural Health, Hospital, Industrial Health, Mental Health, Maternal and Infant Welfare, Chronic Illness, Liaison Advisory Board on Crippled Children, Legislation and Medical Civil Preparedness.

It was further recommended and approved that the chairmen of these committees by and large compose the membership of the Public Health Committee.

It was also recommended and approved that each of these chairmen meet with members of the Department of Public Health within 60 days to effect better liaison and to receive background material on the projects and planning of the State Department of Public Health. Dr. Sappington discussed the idea that at some future date the MAG Constitution and By-Laws be changed to make the chairmen of the nine committees mentioned above active members of the Public Health Committee and to make these same nine committees subcommittees of the Public Health Committee. In that way it was thought that better inter committee liaison may be effected, and the MAG relationship with the Georgia Department of Public Health be improved.

Dr. Sellers heartily endorsed this proposed organization and thought it also would improve the projects and planning of the committees involved.

Dr. Sappington moved that the chairmen of these nine committees be requested to attend the next meeting of the Public Health Committee.

Reports were received for the information of the Public Health Committee from the various members of the Georgia Department of Public Health.

Dr. Rutland discussed the district plan for extension of local health services. This information was referred to the Rural Health Committee.

Dr. Rutland discussed dental care through local health departments, and this information was also referred to the Rural Health Committee.

Dr. Petrie discussed the program of home treatment of tuberculosis and the new commitment law for tuberculosis. This report was referred to the Rural Health Committee and the Industrial Health Committee.

Dr. Petrie discussed the State VD program which he said is at present inadequate because of reduction of federal funds. This information was referred to the Rural Health Committee and Industrial Health Committee.

Dr. Rice presented a map showing the location of Child Guidance Centers in the State. This information was referred to the Mental Health Committee.

Dr. Rice discussed the Crippled Children's Program and his report was referred to the Liaison Advisory Board to the Georgia Society for Crippled Children.

Dr. Venable discussed appropriations needed to supply immediate needs. He stated that \$1,020,000.00 is needed above presently available funds. His report was referred to the Committee on Legislation.

Dr. Williams discussed the Medical Facilities Act of 1954 which will provide \$579,000 for Georgia for the construction of chronic disease hospitals, nursing homes, rehabilitation centers and diagnostic and treatment centers. This information was referred to the Committee on Hospitals.

Dr. Petrie presented a progress report on Civil Defense which was referred to the Committee on Medical Civil Preparedness.

Dr. Sellers discussed the home safety program sponsored by the Kellogg Foundation and asked for MAG endorsement. This information was referred to the next meeting of the Council of the MAG.

At a meeting of the Public Health Committee held at 2 p. m., Sunday, January 16th, Academy of Medicine, the following members were present: T. A. Sappington, Chairman; R. F. Spanjer and T. F. Sellers. Invited to attend the meeting for reorganizational purposes were the following MAG committee chairmen: Duncan Shepard, Industrial Health; George Nicholson, Rural Health; Edgar Dunstan, Medical Civil Preparedness; J. C. Hughston, Georgia Society for Crippled Children; Peter Hydrick, Maternal and Infant Welfare; and L. Minor Blackford, Chronic Illness. Also in attendance from the Georgia Department of Public Health were the following members: John R. Venable, R. C. Williams, S. C. Rutland and Lester M. Petrie. In addition in attendance was Helen Bellhouse, Secretary of the Maternal and Infant Welfare Committee; David Henry Poer, Association Secretary and Mr. Milton D. Krueger.

Chairman Sappington read from the MAG Constitution and By-Laws the structure and purpose of the Public Health Committee. He then proposed that if the Public Health Committee had delegated to it matters that crossed other Association committee lines, he believed that the MAG Public Health Committee should act as a clearing house and that the committee should concentrate its activity on correlating public health problems within the other committees.

Chairman Sappington explained that he believed it in the best interest to have the public health committee composed of a chairman and a member of the Georgia State Department of Health (appointed by the Association president annually). He further proposed that the rest of the committee should be made up of Association committee chairmen whose committees were concerned with some portion of the broad term public health committee. He stated this then would keep the Public Health Committee out of the realm of other committees and prevent the overlapping of activities by these other Association committees. He suggested that the Public Health Committee meet at least annually right after committee appointments were made by the incoming president, to report on each of the other committee's projects and program and correlate their activities. All the other committee chairmen present were in favor of Chairman Sappington's plan.

After this unanimous approval of the plan, Chairman Sappington instructed the executive secretary to draw up a revision of the present MAG Constitution and By-Laws relative to the structure and function of the Public Health Committee and transmit this to J. W. Chambers, Chairman of the MAG Constitution and By-Laws Committee, for action of the House of Delegates.

The new structure and function of the Public Health Committee would then be as follows:

"By-Laws. Chapter IX. Section G. THE COMMITTEE ON PUBLIC HEALTH. The Committee on Public Health shall be composed of a chairman and a member of the Georgia State Department of Health appointed by the president of the Medical Association of Georgia and the chairman of each of the following Association committees: Industrial Health, Rural Health, Hospitals, Legislation, Medical Civil Preparedness, Mental Health, Crippled Children, Maternal and Infant Welfare, Chronic Illness, Cancer, Insurance Board and Blood Banks. The chairmen of these committees shall then automatically be members of the Association Public Health Committee and shall select an alternate member from each of their respective committees to represent them at Public Health Committee meetings in the absence of the chairman. It shall be the duty of the Public Health Committee to meet at least annually to hear reports from the committee chairman members so named and to correlate their activities and to act as a "clearing house" for any matters concerning public health. It shall also be the duty of the Public Health Committee to correlate these activities with the Georgia Department of Public Health."

Chairman Sappington then called for reports from the committee chairmen present for informational purposes only.

Chairman Shepard, Industrial Health Committee, reported on the following projects undertaken by this committee.

(1) Revision of workmen's compensation laws by legislation.

(2) Liaison between the MAG Industrial Health and insurance carriers.

Chairman Nicholson, Rural Health Committee, reported on the following projects undertaken by the Rural Health Committee.

(1) Physicians' placement; (2) public education for utilization of medical facilities existent in rural areas; immunization program for Georgia; (5) improved mental health care for rural areas; (6) recruitment of para- (3) home and farm accident prevention; (4) standard medical personnel for rural areas; (7) county medical society visitation program to disseminate and educate physicians in rural health problems; (8) State rural health conference after previous projects have been completed; and (9) liaison with the farm bureau, 4-H Clubs and other interested groups for improvement of medical care in rural areas.

R. C. Williams reported on a visit with Chairman Seamans, Hospitals Committee, at which six or eight projects for the Hospitals Committee were discussed. A few of these were hospital accreditation, hospital medical staff organization and refresher work for hospital technicians.

Mr. Krueger reported on a recent meeting of Chairman Coker's Legislation Committee at which the following legislation was discussed: (1) new osteopath amendment, (2) creations of a state agency for the visually handicapped, (3) rabies bill, (4) hospital construction bill, (5) injunction law, (6) workmen's compensation revision legislation, etc.

Chairman Dunstan of the Medical Civil Preparedness Committee reported on Civil Defense General Order 13 which divides the State into areas for organization purposes and allows better coordination. He also reported on the availability within the next four months of a 200 bed portable hospital to be used over the State for instructional purposes. Another item he discussed was the coordination of civil defense with the Red Cross and the Association.

Chairman Hughston of the Crippled Children's Committee reported on the national program for a gradual amalgamation of all crippled children's facilities in Georgia. He stated that they must go slowly on this amalgamation so as not to violate organizational autonomy.

Chairman Hydrick and Secretary Bellhouse of the Maternal and Infant Welfare Committee reported on their committee's investigation of maternal deaths using the North Carolina plan. Also included in their investigation is infant mortality. They noted an excellent response to this survey. Dr. Hydrick also mentioned his committee's organization of key men for contacting district and county medical societies with data from his committee's organization of key men for contacting district and county medical societies with data from his committee such as birth certificates, education, etc.

Chairman Blackford, Chronic Illness Committee, is at present working with the State Department of Public Health and the Federal Government on a survey of chronic illness in Georgia as funds are available at the present time.

Dr. Sellers, Director of the State Department of Public Health, reported on certain budgetary inadequacies and gave specific cases for information to the

group. He reported that a Study Committee has been appointed by the Governor to investigate the "real" needs of his department and this study committee will report in June of 1955.

Association Secretary David Henry Poer commented on the one year term of office of committee chairmen and reported that it was his hope that the term of office of Association committee chairmen would be lengthened to allow a better understanding of committee work gained through experience by the chairmen.

Reference Committee recommendation—The reference committee approved the report of the Public Health Committee.

House of Delegates action—Recommended adoption of the Public Health Committee report as presented by the reference committee, which was moved, seconded, and adopted.

Public Relations Committee

Christopher J. McLoughlin, Chairman

The Public Relations Committee had a very rewarding year in 1954, even though we made much less of a 'splash' publically. We had the satisfaction of seeing much former work bear fruit, in the efforts of smaller societies and the responsibility of seeing that their programs had our fullest cooperation and the benefit of our experience. In many small ways we had opportunities to follow up and cement the gains made in the past. Planning and working toward a better public relations program was the aim throughout the year, and it is hoped the results of these efforts will be more apparent with each succeeding year.

During the past year the most note-worthy result of the ground work of previous years was the series of forums held throughout Georgia. It is believed that our state held more forums during 1954 than any other state in the union, and the nation-wide attention given the forums continues to be shown in inquiries received. The Georgia forums, of which there are at least 84, were very well received by the public. A great many of the societies plan to present them again this year. The committee gives help with these programs whenever it is requested.

One project of former years, the exhibit at the Southeastern States Fair, was dropped this year because of the difficulty of staffing an exhibit adequately at all times.

A very definite need was felt for a guide book outlining a program of public relations projects. In the Fall, work was begun on a book of this kind directed especially at the needs of the local societies in Georgia. About this time the Public Relations Committee of the American Medical Association developed a booklet similar to the one we had planned. These AMA books, covering the same material, are much larger and more complete than anything we could afford to publish, so it was decided that to avoid unnecessary expense we should forego our project and make use of the material provided by AMA.

The challenge of building a public relations program throughout the state called for more definite plans for the future activities of the committee. In December we met in Macon, in conjunction with a special called meeting of the House of Delegates. It was decided our efforts toward a public relations program would be more effective if directed on a district, or at least regional, basis. We would not, however, lessen our efforts to strengthen any of the weaker local societies. The committee has worked with the headquarters office in planning a series of meetings on a regional level, the first of

which was held in Thomasville. The president and secretary of each society in the region are invited to these meetings. With each group we plan to:

- a. Explain the basic requirements for a county society.
- b. Stress the need for a definite plan for public relations.
- c. Present each county society with a Minutes' Book, especially prepared for that society, and containing a copy of the charter of its local society and that of the MAG.

It is hoped that this procedure will encourage the stronger societies to maintain proper and comprehensive records of their activities, and less active societies will be stimulated into new progress.

The committee has cooperated with the headquarters office in working with many committees throughout the year. Plans have been formulated for comprehensive coverage of the Annual Session in Augusta and will be in full operation by the time this is published.

By way of recommendations, we would suggest that sufficient funds be allocated to permit one man in the headquarters office to spend at least half of his time traveling through the state. We have felt increasingly that the work of the Public Relations Committee is closely integrated with that of every committee in the society and that all effort and money directed toward public relations work is for the greater good of us all.

The cooperation of all on the committee is deeply appreciated, and the committee as a whole is especially indebted for the assistance of the headquarters office.

Reference Committee recommendation—The reference committee approves this report.

House of Delegates action—Recommends the adoption of the Public Relations Committee report as presented by the reference committee which was moved, seconded, and adopted.

Hospitals Committee

H. Ansley Seaman, Chairman

The functions of the Committee on Hospitals include consideration and review of problems that arise in relation to hospitals and the medical profession in the State of Georgia. This is intended to outline some of the problems that currently face us in order that members of the committee may give consideration to how these and similar problems may best be solved.

At the present time there are approximately 240 hospitals in Georgia. Eighty per cent of the hospitals are 50 beds or less. A number of the hospitals with 50 beds or less are small institutions operated by individual physicians; they vary in size from five to 10 or 12 beds. The following classification of hospitals in Georgia may be of interest:

<i>Size</i>	<i>Number of Hospitals</i>
Less than 16 beds	90
16-50 beds	97
51-99 beds	23
100-149 beds	18
150-250 beds	4
Above 250 beds	6
<hr/>	
238	

Since 1947, 45 new hospitals have been completed in Georgia under the Hill-Burton program. Eight hospitals are now being constructed under that program. Five additional hospitals have been approved for construction. Nine hospitals have had additions and al-

terations under this program that have been completed. Six hospitals are now in the process of receiving additions and alterations through that program.

Under an act of the General Assembly in 1946, the licensure of hospitals operated in this state was made a function of the Georgia Department of Public Health. This licensure program is operated through the same branch of the Georgia Department of Public Health that conducts the Hill-Burton Construction Program.

Perhaps the most fruitful field in which our committee can be of service is with reference to problems confronting hospitals of 50 beds or less. It is hoped that the suggestions presented below may be developed and expanded so they may be of real service to the smaller hospitals of the State and to the physicians serving them:

1. The formal organization of the staff of any hospital is important even though there may be only four or five physicians on the staff of a given hospital. It is felt, therefore, that emphasis should be placed upon medical staff organization, the holding of regular staff meetings, and maintaining minutes of these meetings.

2. The Joint Commission on Accreditation established by the American Medical Association, the Canadian Medical Association, the American College of Surgeons, the American College of Physicians, and the American Hospital Association, functions as the representative of these professional bodies to stimulate and encourage necessary standards in the operation of hospitals. The Joint Commission has a fulltime staff and several field representatives. The importance to all hospitals of 25 beds or more of securing accreditation cannot be overemphasized. The Hospitals Committee by visiting the smaller hospitals and working with members of the medical staff can be of real assistance in stimulating interest in accreditation for such hospitals.

3. One of the factors that acts as a deterrent in securing accreditation, particularly in smaller hospitals, is the inadequacy of medical records maintained. The Hospitals Committee can be of definite assistance in interesting members of the medical staff of smaller hospitals in the importance of maintaining adequate medical records. Conferences with medical staffs relative to this and perhaps programs in the district and county medical societies relative to medical records would be useful.

4. Through the Division of Hospital Services of the Georgia Department of Public Health, refresher courses for medical technologists have been presented in four areas of the state. Ninety-eight technologists attended these recent refresher courses representing 46 hospitals. These courses were a review of the usual routine techniques used in clinical laboratories. Subjects presented included hematology, urinalysis, biochemistry, and blood bank techniques. These refresher courses for laboratory technologists are the means whereby hospitals served by physicians in Georgia may profit by having recent developments in various laboratory procedures brought to their attention. The refresher courses should be continued.

5. Although conditions vary in different geographic areas of the state, it appears that in some sections there is need for a voluntary reciprocal blood bank program designed to meet the growing needs of hospitals. Procurement and distribution of necessary blood and blood derivatives are among the more important aspects of

this problem. A plan by which blood may be made available to the areas of greatest need in the state is worthy of consideration. Any plan for blood bank reciprocity should include a means of guaranteeing the high quality of blood both from the donor selected and the methods of processing and shipping.

6. With the current use of anti-coagulant drug therapy, the accurate utilization of these drugs hinges on dependable laboratory results. The U. S. Public Health Service has a group of specialists in this field who are available to states which would like to encourage training in the current advances in these techniques. It might be desirable for the Hospitals Committee to encourage the presentation of demonstration courses on the clotting activity of blood and the prothrombin time test that would be valuable both to laboratory technologists and to physicians who are interested in anti-coagulant therapy.

7. The Division of Hospital Services of the Georgia Department of Public Health has recently distributed to hospitals and physicians in the state a *Georgia Hospital Diet Manual*. This manual was prepared in recognition of the need for uniformity in prescribing modified diets. The Hospitals Committee could render useful service to food service directors and hospital personnel in the state by advocating adherence to uniformity in the prescription of modified diets. It is especially important that the terminology be clarified so that the hospital food service supervisor can use her reference material on modified diets more accurately.

8. The experience of some physicians in Georgia indicates the need for specific refresher work for hospital food service supervisors particularly toward therapeutic diets such as those made for diabetic patients, for patients requiring salt free diets, and low sodium diets. The Hospitals Committee could undoubtedly be useful in assisting and planning for refresher work by the Division of Hospital Services in therapeutic diets in several areas of the State.

Your prompt comment relative to these suggestions will be appreciated.

Recommendation

WHEREAS, the duty of the Committee on Hospitals of the Medical Association of Georgia is to study and improve the relation of the medical profession to the operation of public and private hospitals within this state, and

WHEREAS, the Committee on Hospitals should confer with related agencies and organizations to further these objectives.

NOW THEREFORE BE IT RESOLVED by the House of Delegates of the Medical Association of Georgia, the approval of the Committee on Hospitals recommendation to create on a state level, a joint commission to study and recommend hospital standards in Georgia as these standards relate to the medical profession;

BE IT FURTHER REOLVED, that this joint commission be composed of representatives of the Medical Association of Georgia; Georgia Academy of General Practice; Georgia Chapter, American College of Surgeons; and the Georgia Hospital Association.

Reference Committee recommendation—This report is approved by the reference committee with the recommendation that more hospitals take advantage of the refresher courses offered in various

hospital departments. The recommendation offered by the chairman of the Hospitals Committee is also approved except for the recommendation that the word "joint" be deleted.

House of Delegates action—Recommended adoption of the report of the Committee on Hospitals and their recommendation on hospitals as presented by the chairman with the reference committee notation concerning the deletion of the word "joint." This motion was seconded and duly adopted.

Abner Wellborn Calhoun Lectureship Committee

Glenville Giddings, Chairman

The Andrew Wellborn Calhoun Memorial Lecture will be delivered by Dr. Frank B. Berry, Assistant Secretary of Defense, Washington, D. C., at 12:00 noon on Tuesday, May 3, 1955. The title of his address is "The Medical Manpower Situation in This Country and Overseas."

Reference Committee recommendation—The reference committee approves this report.

House of Delegates action—Recommended adoption of the Abner Wellborn Calhoun Memorial Lectureship Committee as presented by the reference committee, which was moved, seconded, and adopted.

Liaison Advisory Board to the Georgia Society for Crippled Children

Jack C. Hughston, Chairman

The year 1954, relative to the functions of the crippled children's organizations in the state, has been mainly one of initiation of long term plans rather than one of result and accomplishment. It has been the object of all the various organizations referable to the crippled children to work together as much as possible for the benefit of each division without loss of the individual characteristics of each of the organizations. We all realize that considerable strides can be made in the conservation of money expended and results obtained by the utilization of common facilities and functions by the various organizations' maintaining specific interest in special disorders of children which fall into the crippled children's category. We feel that the future years will begin to demonstrate the excellent results obtainable by the close cooperation of these various organizations.

Reference Committee recommendation—The reference committee approves this report.

House of Delegates action—Recommended adoption of the report of the Liaison Advisory Board to Georgia Society for Crippled Children as presented by the reference committee, which was moved, seconded, and adopted.

State Advisory Committee to the Selective Service System

Cyrus W. Strickler, Jr., Chairman

As chairman of the Georgia State Advisory Committee from January 20, 1954, to January 20, 1955, I submit the following resumé of the work of the committee for the year:

There were no induction calls by the Selective Service System for special registrant physicians during the early part of the year, however local boards were ordered during March 1954 to resume the processing for physical examination and induction of Priority I and Priority II physicians of all ages and Priority III physicians born after August 30, 1922. Calls were levied for delivery of five physicians in June, one in July, 12 in August and four in December. Another call was issued in Decem-

ber for delivery of 16 physicians in March 1955. The status of the special registrants included in these calls was investigated and their essentiality or availability passed on by the committee.

In December 1954, we were notified that the Selective Service System had requested the physical examination of physicians up to the age of 37. To meet the national call for 1,275 physicians to be delivered by the Selective Service System in March 1955, it was necessary to use Priority I, all ages; Priority II, without restriction as to months of service; and Priority III born on or after January 1, 1917. Efforts were to be made to make available for service all those Priority III young registrants born after August 30, 1922, to protect the older men of Priority III.

During July 1954, the National Advisory Committee expressed deep concern over the possibility of calling up physicians of Priority III over 31 years of age to meet the needs of the armed forces during the fiscal year of 1955. They pointed out then that every effort should be made to have physicians of Priority I and Priority II and those of Priority III born after August 30, 1922, who would finish internships and residencies by July 1, 1954, to apply for commissions at once to avoid a long period of waiting between the end of the hospital year and the call to duty. They advised then that the men of these groups were urgently needed to meet the calls for the year.

The National Advisory Committee pointed out that the hospitals should not appoint physicians of the above groups for training beyond one year of internship. In line with suggestions made, a check of the lists of interns and residents submitted by the hospitals of Georgia was made. We investigated the status of all physicians listed of Priority I, II and III under 32 years of age, who had not already had recommendations of availability made by the committee. Recommendations were made concerning these men to the Georgia local boards or to the proper out-of-state advisory committees. Letters with copies of releases concerning interns and residents were sent the Georgia hospitals having such programs and to the medical colleges of the State.

Lists of the 1954 graduates were secured from the State medical and dental colleges. Questionnaires and records were completed concerning these men.

During 1954 the committee considered the essentiality of 107 special registrant physicians and one x-ray technician. The essentiality of 27 dentists was passed on by the dental subcommittee. We also considered the essentiality of 26 medical reserve officers, four dental reserve officers, and two veterinarians.

On receipt of information regarding the pending release from active duty in the armed forces of physicians from Georgia, letters of welcome are written to them offering any possible assistance in relocating. Information has been supplied to several of these men and we have also furnished information regarding replacements to several physicians going on active duty.

A report was submitted to the National Advisory Committee in June 1954, which was in compliance with a request for information concerning the civilian needs for physicians in Georgia. This report covered information concerning communities making efforts to secure practitioners, counties with no physician and those having only one physician. A like report was prepared on

the needs for dentists in Georgia.

It is the aim and purpose of this committee to continue to function to the best of our ability in our advisory capacity. The committee will continue during 1955, under Dr. William G. Hamm as chairman, to furnish the advice and recommendations as needed by the Selective Service System and the armed forces. This is in line with the policy of rotating the chairmanship. Dr. David Henry Poer has been appointed and approved as co-chairman for 1955.

The State Committee has suggested that the District Advisory Committees remain intact as originally appointed. However, they may rotate their chairmanship as the State committee does to relieve any undue burden on a single individual.

We will be glad to have any suggestions from the Association which will be helpful in promoting the usefulness of the committee.

Reference Committee recommendation—This report is approved with the recommendation that Dr. Strickler be commended for his fine report.

House of Delegates action—Recommended adoption of the State Advisory Committee to Selective Service Report as presented by the reference committee which was moved, seconded, and adopted.

Maternal and Infant Welfare Committee

Peter B. Hydrick, Chairman

There have been three meetings of this committee since May 1954, and a good deal of interim activity. The organization and work of the committee particularly related to the recognition of perinatal losses as one index of maternal morbidity has received favorable national recognition in the literature.

Maternal Deaths: 47 of the 130 so far reported maternal deaths have been queried through the physician and recently, when indicated, through the local health department. As of this writing, 35 are complete, anonymized and ready for analysis. Both physician and health department cooperation has been increasingly good in completeness, in speed of reply and in objective analysis. It becomes obvious from preliminary review that the case reports will, when tabulated and summarized, point up broad lacks in prenatal care and in hospital practices and facilities. The frequency of late hospitalization of known toxemia and of lack of adequate blood availability and administration is alarming. The number of coroner's cases is also a matter of concern, as is the problem of ignorance and superstition on the part of the patients. The latter is a real barrier to quality care and supervision.

Fetal Death and Live Birth Certificates: Cooperating with the committee, the Georgia Department of Public Health has reviewed tabulations of and prepared a preliminary report on the experience with the new forms for the first six months of 1954. Certain items are outstanding. In all too many instances, hemoglobin determinations on the mother of the infant are reported as "not done". This omission is hazardous to both. As with the hemoglobin determinations, certain centers caring for large numbers of expectant mothers do not apparently include RH factor determinations. This service is available at no cost to the patient, through the State Department of Health. The report also notes the original new live birth and fetal death certificates were not as comparable as might be desired. Revisions have been made by the health department and the new

forms are now available. Their use will enhance the work of the committee.

Activities with other Committees and Organizations: The committee as a whole and individually have acted in an advisory capacity to the State Health Department in response to an increasing number of requests.

The committee was represented at the Tri-State Obstetric—Pediatric Seminar at Daytona Beach, and Hugh Bickerstaff gave the State report. This seminar was again successful.

A pediatrician member, Tom McPherson, and an obstetrician member, Charles Mulherin, officially represented the committee at the two meetings held by the Department of Public Health directed toward determining and starting action to meet the needs for obstetric and newborn care for mothers in rural Georgia. One sub-committee member, J. L. Walker, was also present, representing the Academy of General Practitioners.

The 10 sub-committee members have functioned in different ways. Several have been most effective in bringing pertinent information to the attention of their district societies, and, for the county in which one member resides, the hospital and medical group have developed a low-cost package care plan for the delivery and new-born period, working with the health department to include postpartal care, and prenatal care.

Recommendations:

To continue reviewing individual anonymized maternal deaths to make both broad and individual recommendations.

To increase the depth and scope of study of perinatal problems, increasing the emphasis on reduction of losses for the infants and the morbidity rate in the mothers. The fetal death and live birth certificates will be helpful.

To continue in advisory capacity to the Health Department on request.

To promote increased lay and professional knowledge of and responsibility for the welfare of Georgia mothers and infants.

Reference Committee recommendation—The reference committee approves the report of the Maternal and Infant Welfare Committee.

House of Delegates action—Recommended adoption of the Maternal and Infant Welfare Committee Report as presented by the reference committee, which was moved, seconded, and adopted.

Resolution on Hospital Accreditation

**Introduced by
Fred Simonton, Chickamauga**

WHEREAS, the American Medical Association is the recognized official organization to represent medicine in the United States and,

WHEREAS, it is not only the privilege but the obligation of this organization to protect and safeguard medical care of the patients and to assist in every way possible to maintain the high standards of medicine and surgery and,

WHEREAS, the AMA is the only organization which can and should speak officially for physicians regardless of which field of medicine they practice and,

WHEREAS, there is a marked growing unrest due to the fact that the AMA has not met its full obligations in regard to accreditation of hospitals for patients' care and,

WHEREAS, there are two phases of accreditation of hospitals, one having to do with strictly housekeeping problems—the part which is unquestionably that of

hospitals—and the other having to do with the care of the patient by the physician, staff organization, and of course, the intern and resident training program, and,

WHEREAS, if this obligation is not met satisfactorily and soon, it will be increasingly difficult to discharge responsibility, which is the patient, whereby we can render him the best medical service in the most economical fashion;

NOW, THEREFORE, BE IT RESOLVED, that, if the American Hospital Association still has the desire to assist in the accreditation of hospitals, they be urged and invited to cooperate with American Medical Association in continuing their accreditation in regard to the strictly physical problem which is unquestionably their responsibility.

BE IT FURTHER RESOLVED, that at this meeting, March 29, 1955, of Walker-Catoosa-Dade County Medical Society those who are delegates to the Medical Association of Georgia support this or similar resolution and that, if favorably passed by the House of Delegates of the Medical Association of Georgia, the Georgia delegates to the American Medical Association present this or similar resolution.

Reference Committee recommendation—The reference committee recommended that this resolution be approved in principle.

House of Delegates action—Lester Rumble, Atlanta, was recognized and made a motion that, in addition to approval of the resolution on hospital accreditation introduced by Dr. Simonton, the problem involved in the accreditation of hospitals, as it affects the required meetings for the approval of a hospital, be given further study and that this study be directed toward the cutting down of meetings by physicians connected with the hospital rather than the increasing of these meetings as required for hospital accreditation. Dr. Rumble's motion was approved after being seconded and was adopted. The House of Delegates also approved the resolution on hospital accreditation as presented by the reference committee with the notation that this resolution "be approved in principle."

Resolution on Oral Prescriptions

**Introduced by
Grady Coker, Canton**

WHEREAS, federal narcotic laws were amended by Congress in 1954 to permit oral prescriptions for narcotic drugs which have little or no addiction; and,

WHEREAS, a change in Georgia law is needed to conform with federal law; and,

WHEREAS, approval was given to the Federal Narcotic Law amendment by the House of Delegates of the Medical Association of Georgia at its 104th Annual Session in Macon;

NOW THEREFORE, BE IT RESOLVED BY THE HOUSE OF DELEGATES OF THE MEDICAL ASSOCIATION OF GEORGIA, that the Uniform Drug Act of Georgia be amended to conform with federal laws so that narcotic drugs of little or no addiction may be sold or dispensed upon an oral prescription.

BE IT FURTHER RESOLVED, that a resolution to this effect be sponsored by the Legislation Committee of the Medical Association of Georgia at the next session of the legislature.

Reference Committee recommendation—It is recommended that this be referred back to the Legislation Committee for further study and consultation with medical members of the Georgia legislature.

House of Delegates action—The House of Delegates approved the recommendation of the reference committee concerning the referral of this oral prescription resolution back to the legislative committee for further study and consultation with medical members of the Georgia legislature.

REPORT OF REFERENCE COMMITTEE
NO. 3

J. M. Byne, Chairman

(The following reports as presented to this committee are printed in full with the reference committee's recommendation and the action pursuant to it by the House of Delegates.) The following members of the reference committee were present: J. M. Byne, Jr., chairman; T. A. Sappington, vice-chairman; R. J. Moye, M. F. Arnold, A. B. Conger, W. H. Fulmer, Lewis R. Lang, W. C. McCarver, C. M. Mulherin, and Irving L. Greenberg.

Immediate Past-President
William Harbin

At the request of President Wright and with the approval of the Executive Committee of Council, I have worked with this committee in an advisory capacity. It has been my privilege to attend the majority of the meetings of this committee and of Council, at which time many important matters were acted upon. As a member of the Professional Conduct and the Constitution and By-Laws Committees, I have participated in the activities of these committees. The office personnel of the Association is to be highly commended for the excellent work they have done during the past year and the able assistance they have rendered the House of Delegates, Council and the committees of the Association.

Reference Committee recommendation—Reference Committee No. 3 recommends the adoption of the Report of the Immediate Past President without change.

House of Delegates action—Recommended adoption of the Immediate Past President's report as presented by the reference committee, which was moved, seconded, and approved.

Seventh District Councilor
D. Lloyd Wood

The Seventh District shows an increase in membership in both the MAG and AMA. MAG members number 224 which is an increase of 20 members over 1953. AMA members number 164 showing an increase of 16 members over 1953.

The district society has had two excellent meetings, one in the Fall and one this Spring in April.

The county societies are functioning quite well.

Congratulations are in order to Tri County Hospital for becoming accredited.

Seventh District Membership

Counties	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
Bartow	9	8	9	9
Carroll-Douglas-Haralson	38	22	38	18
Chattooga	7	6	7	7
Cobb	38	31	37	32
Floyd	56	43	46	35
Gordon	12	10	10	8
Polk	17	10	17	11
Walker-Catoosa-Dade	27	21	20	16
Whitfield	20	13	20	12
Total	224	164	204	148

Reference Committee recommendation—Reference Committee No. 3 recommends the adoption of the report of the Seventh District Councilor without change.

House of Delegates action—Recommended adoption of the

Seventh District Councilor's report as presented by the reference committee, which was moved, seconded, and adopted.

Eighth District Councilor
Neal F. Yeomans

The Eighth District is composed of seven county medical societies, four of which are small and three of which are large and very active. The past year has been marked by moderate progress in most instances with only a few exceptions to mar an otherwise good report. Medical forums have been held and grievance committees, while not generally active, are being formed and will probably be more active as time goes by. Tissue committees have been established in the larger hospitals and are contributing much to the benefit of all.

Eighth District Membership

Counties	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
Altamaha (Appling)	7	7	8	7
Coffee	14	8	14	8
Glynn	32	28	23	21
South Georgia (Berrien- Clinch-Cook-Echols- Lanier-Lowndes)	38	34	35	30
Telfair	10	9	11	10
Ware	51	41	54	43
Wayne	3	8	9	9
Total	160	135	154	128

Reference Committee recommendation—Reference Committee No. 3 recommends the adoption of the Eighth District Councilor's report without change.

House of Delegates action—Recommended adoption of the Eighth District Councilor's report as presented by the reference committee, which was moved, seconded, and adopted.

Ninth District Councilor
W. Bruce Schaefer

Councilor from the Ninth District reports approximately 10 per cent increase in doctors in 1954 over 1953; it has definitely been one of the best years the Ninth District has ever seen. There is general activity over the entire district. The district meeting in Winder was well attended having approximately 75 present. The scientific as well as the social program was very good.

The Ninth District Spring Meeting will be held in Toccoa April 13th at which time an excellent scientific program has been arranged by the Stephens County Medical Society followed by social program and dinner. It is expected to be as equally well attended.

The Ninth District Newsletter is edited by our very able secretary, George T. Nicholson of Cornelia. It is growing by leaps and bounds, both in size and prestige. The AMA has requested 30 copies, as well as several other state organizations. We feel this letter has done a great deal to increase the interest in the district society, increasing the number of our dues-paying members in the district. And we are ending the year with a financial surplus.

The Ninth District shows probably a great number of physicians members of MAG who are not members of AMA, but we feel this is due to the longevity which exists in these hills. We have so many doctors who have retired and who wish to maintain their membership with the state but do not feel the need of AMA at this time.

Ninth District Membership

Counties	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
Banks	1	1	1	1
Blue Ridge	10	7	11	8
Cherokee-Pickens	14	9	13	9
Forsyth	5	4	5	4
Gwinnett	12	4	10	3
Habersham	16	14	17	15
Hall	37	26	33	24
Jackson-Barrow	18	13	17	12
Rabun	4	4	3	3
Stephens	13	11	12	10
Total	130	93	122	89

Reference Committee recommendation—Reference Committee No. 3 recommends the adoption of the Ninth District Councilor's report as it was presented by the reference committee, which was moved, seconded, and adopted.

House of Delegates action—Recommended adoption of the Ninth District Councilor's report as it was presented by the reference committee, which was moved, seconded, and adopted.

Medical Education Committee

R. Hugh Wood, Chairman

The Medical Education Committee has not had a meeting during the year, and no questions or problems have been referred to it.

Emory University School of Medicine has discontinued the five-day postgraduate course for general practitioners and substituted a series of seven one-day courses. These have had a better attendance and seem to be more popular. In addition, one three-day course in general medicine and surgery was given on December 7, 8 and 9, 1954.

The Medical College of Georgia reports that due to problems of reorganization they were unable to give any postgraduate courses during the year.

Medical education at the undergraduate, graduate and postgraduate levels should be the vital concern of every physician. The quality of medicine practiced can be no better than the quality of medical education. Most medical schools are doing a high-quality type of undergraduate teaching, but if they are to take leadership in the continuing education of physicians and in the rotation of interns to smaller community hospitals and participate in planning for better medical care in appropriate ways, they will need to have more financial support. It is increasingly difficult to secure and retain highly qualified faculty members at salaries the schools can pay. This brings us face to face with the problem of how the full-time faculty member can supplement his modest salary. A fair, reasonable and ethical way must be found. The same factors are encountered in the financing and operation of teaching hospitals.

Many groups in the State, including the Council of the Medical Association of Georgia and the House of Delegates, have concerned themselves with this question. At the national level the Council on Medical Services of the American Medical Association has undertaken a study which will have the collaboration of the Association of American Medical Colleges and the American Hospital Association. Calm, seasoned judgment is needed. No one perfect scheme for all schools is likely to evolve, but certain guiding principles can be stated which will help the schools, the hospitals and the practicing physicians to reach a common understanding and philosophy. Some way must be found to support

medical schools within the framework of private enterprise.

Since the committee has not had a meeting, the chairman takes responsibility for these latter observations.

Recommendation Submitted on the Floor of the House of Delegates

The Maternal and Infant Welfare Committee of the Medical Association of Georgia, in attempting to realize an ambitious program for correcting certain procedures with maternal and infant morbidity in the State of Georgia, seeks to enlist recommendations and aid from both medical schools in their program and recommends that the medical schools cooperate more fully in this program.

Reference Committee recommendation—Reference Committee No. 3 recommends the adoption of the Report of the Medical Education Committee and the Recommendation submitted on the floor of the House of Delegates at the first session, and also wishes to recommend the following resolution:

"That the Medical Education Committee be enlarged and that it participate more actively in sponsoring and carrying out a more comprehensive program in graduate medical education.

That members of the faculties of the Medical College of Georgia and of the Emory University School of Medicine be included on this committee."

House of Delegates action: Recommended adoption of the Medical Education Committee report, and the Recommendation submitted on the floor of the House of Delegates and the recommendation as presented by the reference committee, all of which was moved, seconded, and adopted.

Cancer Committee

J. Elliott Scarborough, Chairman

The Committee on Cancer has held three called meetings during the past year, chiefly for the purpose of advising with W. J. Murphy concerning the Cancer State Aid program in Georgia. Due to curtailment of federal aid, as well as state aid, the program found itself faced with carrying on the care of indigent cancer patients with a reduction of about \$50,000.00 in funds.

The first meetings was held in Macon, on May 5, 1954, at the Dempsey Hotel in conjunction with the Medical Association of Georgia Annual Session. The clinic directors were invited, and it was agreed that certain services could be put off for the month of June in order to keep the program going.

The second meeting was held at the Sheffield Clinic, Georgia Baptist Hospital, on October 13, 1954. At this meeting the clinic directors and hospital superintendents met to discuss the ways and means of keeping the services of the State Aid program going with curtailed funds. It was pointed out by the hospital superintendents that the cost of hospitalization was going up, but they discussed the problem sympathetically and with one exception agreed to continue the program. The University Hospital at Augusta had been forced to discontinue the program for economic reasons, but Mr. Whitlaw H. Hunt, Superintendent, expressed his continued interest and his hopes for rejoining the program in the near future. The chairman believes that this meeting accomplished more for understanding and support of the State Aid program than any that has ever been held before. Shortly after the meeting the University Hospital at Augusta applied for reinstatement and at the third called meeting on January 20, 1955, the committee voted to advise Dr. Murphy to reinstate the Bernard Cancer Clinic. The Augusta Clinic has been a member of the State Aid program ever since its beginning in 1937.

At the third meeting held at the Biltmore Hotel on January 20, 1955, the committee also voted to recommend that members of the Cancer Committee of the Medical Association of Georgia visit the various State Aid approved clinics throughout the State so that the committee would be more familiar with their local situation and general operation and thereby be in a better position to assist them in their problems.

Mention should be made of the fact that the committee has had the support and interest of the American Cancer Society, Georgia Division, and Mr. Lon Sullivan, Executive Vice-President, was invited and has been present at all of our meetings. The Cancer Committee continues to sponsor educational and scientific programs in cooperation with the Georgia Division of the American Cancer Society. Clinical meetings were held by the West Georgia Cancer Committee, LaGrange, on August 19, 1954, and the American Cancer Society, Atlanta, January 21, 1955.

During the year, the State Aid cancer clinics have been inspected by the American College of Surgeons, consistent with their program of carrying out this service every two years.

The chairman appreciates the interest of the entire committee and especially the Executive Committee, which has been most cooperative and on several occasions the members have inconvenienced themselves in order to be present at the meetings.

Reference Committee recommendation—Reference Committee No. 3 recommends adoption of the report of the Cancer Committee without change.

House of Delegates action—Recommended adoption of the Cancer Committee report as presented by the reference committee which was moved, seconded, and adopted.

Medical Civil Preparedness Committee

Edgar M. Dunstan, Chairman

This year again the work of the committee was intimately connected with that of the Medical Services Branch of the State Civil Defense Health Services Division, which has been in operation since February 19, 1951. Our committee is the main advisory group for this branch. Full minutes of the activities of this branch are in the official files.

Representatives of this committee attended the regular monthly school sessions and other meetings of this branch throughout the year and participated prominently in the following key activities:

1. The American Medical Association-sponsored 1954 National Civil Defense Conference in San Francisco at which the pamphlet, "What Every Georgia Citizen Should Know About His or Her Civil Defense Health Services", was first presented.
2. Contributed a paper, "Civil Defense Responsibilities of Physicians" in a series of six which appeared successively in the *Journal of the American Medical Association* and were later published and distributed by the A.M.A. in a booklet entitled "Medical Planning for Civil Defense".
3. Participated in the deliberations for obtaining an Improvised Hospital from the Federal Civil Defense Administration for training purposes in Georgia. Delivery of this unit is expected this Spring and should provide the stimulus for stepping up the training program with area-wide practice runs.
4. Took part in conferences with key Red Cross

personnel to work out standardization of mobile teams so that these can be used interchangeably in natural or enemy-caused disasters.

5. Cooperated with the Health Services Implementation Committee of the Federal Civil Defense Administration (Region 3) in the vital work of coordination of General Order No. 13 with the other southeastern states.

The State Civil Defense General Order No. 13 (Operational Plan No. 1) released January 1, 1955, specifies the definite evacuee assignment areas in connection with the five main target areas in the State, namely, Atlanta, Savannah, Augusta, Macon and Columbus. It also assigns the counties in the extreme northwest to Chattanooga, those in the extreme southeast to Jacksonville, those in the extreme southwest to Tallahassee, leaving an unassigned area centering around Albany which will furnish mobile support wherever needed in a disaster. These specific assignments now make possible the area-wide exercises which are so essential to proper functioning when a disaster occurs.

The committee recommends that the 1955-56 Medical Civilian Preparedness Committee be composed of a physician from each of these six key areas of the State together with any other member-at-large which the president may wish to appoint.

Reference Committee recommendation—Reference Committee No. 3 recommends the adoption of the Report of the Medical Civil Preparedness Committee without change.

House of Delegates action—Recommended adoption of the Medical Civil Preparedness Committee Report as presented by the reference committee, which was moved, seconded, and adopted.

Eugene Talmadge Memorial Hospital Study Committee

Lester Rumble, Jr., Chairman

If no other report in this issue is read, this one should be read by each voting member, particularly those who will attend the meeting of the House of Delegates.

At the called meeting of the House of Delegates in Macon in December the following actions were taken:

1. The proposed plan of operation of the Eugene Talmadge Memorial Hospital was modified to include the admission of *only* indigent patients. The corollary of this would then be that no one capable of paying would be admitted to this hospital.
2. This study group was appointed in response to a statement (which those present in Macon will recall) by Dr. Pund that he had received no alternative plan for the operation of the hospital. Our purpose was to devise a plan which would meet with the unqualified approval of the Medical Association of Georgia, the State Board of Regents (who will supervise the hospital once it is completed), the administration of the Medical College of Georgia and conform to State Laws.

The basic objection to the plan as presented by Dr. Pund was the inclusion of a mechanism whereby fees for doctors' services (professional fees as distinguished from charges for hospital services) were to be collected by the hospital through its bursar and thus would become a part of the hospital funds. In spite of the statement by the administrative heads of the Medical College that paying patients would be kept at a minimum and that these funds would be devoted to research and not to the operation of the hospital, the study group felt that this arrangement is not an acceptable one to the

medical profession of the State of Georgia. Our reasoning was as follows:

1. The code of ethics under which medicine has been practiced in these United States for many years, (as a result of which we feel has been responsible for the advancement of medical science to its high plane) states that,

"A physician should not dispose his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

From this standpoint alone, the plan presented in Macon and the subsequent plans which have been presented by the administrative staff of the Medical College of Georgia cannot be acceptable to the physicians of Georgia, since there is in each of them the *possibility* of exploitation of the physicians working for the hospital. Thus our problem was to develop a plan which would meet the ethical standards of the profession and the acceptance of the other parties mentioned.

Now here, I must add some parenthetical remarks, since this committee approached this problem with much study and with due consideration of several factors. In the first place, we desired to do nothing which would in any way jeopardize the teaching program at the Medical College of Georgia. Many of the committee members are loyal alumni of this school. Above that, any doctor practicing in any state, if he has his wits about him at all, realizes that the presence of several excellent medical schools will help him and his patients in their common desire to maintain health. By the same token, however, a thinking doctor will realize that a school that demonstrates by its policies a practice which is unethical will gradually (although unconsciously) undermine the ethical practice of medicine, by precept if not by design. None of us anticipates that the present group of individuals involved in the establishment of this hospital has any desire to exploit the physicians who become employed there by encouraging them to accept more and more paying patients, in order that the fees for their services to these patients may be used to ease the strain of the budget of an 800 bed hospital. But, if the possibility of exploitation (as it exists under the present plan) is permitted to be written into the original plans for operation, then a few years from now the present administration of the State and of the College may be occupied by individuals who do not have the high ideals of those now in office, and we could see the day arrive, when by advertisement or other means, the Talmadge Hospital could be occupied by primarily paying patients. From this source the hospital budget could be greatly relieved by the daily "take" from professional fees. We need not pursue this line of thought any further.

The second consideration was the fact that it would be quite unfair (if not illegal) to prevent paying patients from receiving care in this institution. The legislative act which established the hospital was later modified to read that it was to take care of "indigent, semi-indigent and paying patients". Thus some mechanism had to be evolved whereby physicians fees could be

collected without the possibility of the physicians becoming sources of income for the state.

The third consideration was the fact that any plan of operation had to meet the legal requirements of the state in regard to handling moneys.

The last consideration was the fact that if the State of Georgia establishes this system of the corporate practice of medicine, it will become a precept and will be the same as passing a legislative act which legalizes this system of medical practice. This matter has been contested in many other states, and in every instance the court decision has been rendered that the corporate practice of medicine is contrary to the public "weal" (interest) and thus is illegal, in any form. This matter has not been tested in the State of Georgia, but there is no reason to assume that the judges of our state will be in disagreement with other legal opinions.

This is the point at which we started. After several weeks of investigation, and after a full week-end of group discussion, not only by the study group, but by the combined study and advisory groups, with the help of representatives called in from over the entire state, we evolved the following plan. A representative of the Talmadge Hospital was present at all meetings and active in the discussion.

"(1) The Medical College of Georgia will have a full-time faculty of key administrative men. This full-time faculty will be allowed referral practice in the Talmadge Memorial Hospital and consultation privilege in other hospitals. These activities of the full-time faculty are to be limited by the president of the Medical College of Georgia in such a way as to assure that proper teaching and research duties are not neglected.

"(2) The Medical College of Georgia will have a part-time faculty who will do a major part of the teaching and also participate in the research program. The part-time faculty men will have the privilege of having pay patients in the hospital, although it should be understood that the total number of pay beds will be limited.

"(3) Pay patients for the Talmadge Memorial Hospital will be referred to individual physicians on the faculty. Indigent patients for the Talmadge Memorial Hospital will be referred to the proper service in the hospital. All patients in the Talmadge Memorial Hospital will be considered teaching patients.

"(4) All moneys collected by the Talmadge Memorial Hospital faculty (who will collect their own bills) will be pooled in a separate research fund, administered by a group consisting of (1) a member of the Medical Association of Georgia appointed for a three year term by the Association president; (2) a member of the Board of Regents; and (3) a member of the Medical College of Georgia faculty.

"(5) The operation of the Talmadge Memorial Hospital will be under the continual observation and counsel of the Board of Regents and its medical advisory group (one physician representing each congressional district as recommended by the Medical Association of Georgia's 10 district medical societies)."

The only objection that was raised to this plan was the fact that it was contrary to the Constitution of the State of Georgia. This opinion, however, was not a written one, but a verbal one. Thus the group approached the problem by sending this plan to the Attorney-General of the State, for a written opinion regarding legality. This had to be accomplished by asking Dr. Pund to submit the plan to the Board of Regents,

who in turn were to submit it to the Attorney-General for comment. It is impossible for the Medical Association of Georgia to submit the plan directly to the Attorney-General, since requests for opinions must come through a State Office.

Dr. Pund complied with our request. To the date of this writing, no word has been received, although direct contact has been made with the secretary of the Board of Regents. It is hoped that by the meeting of the House of Delegates that the opinion that this plan is legal will have been received, and that this plan can be presented for the approval of the Medical Association of Georgia.

You will notice that this plan varies little from that of Dr. Pund, except in the manner in which the moneys for professional services will be collected and the manner in which they will be administered toward research projects. This effectively removes the profit motive which might become a temptation to someone trying to balance a budget. In addition, we feel that it will enhance the teaching effectiveness of the Medical College, by relieving the men of professorial rank of the pressure of private practice, without removing them from the situations in which their particular knowledge and skill is desirable.

At the Board of Regents' March 9, 1955, meeting the following resolutions for the operation of the Eugene Talmadge Memorial Hospital were passed. These resolutions are presented for your information. In light of the findings of the Study Committee, the House of Delegates should be prepared to take positive action.

"RESOLVED, That the Board of Regents of the University System of Georgia shall, and it does, hereby declare its policy to be the development of a strong center for medical education at the Medical College of Georgia. The declaration of this policy places an obligation upon the Medical College to furnish services requested by physicians which will aid in the diagnosis and treatment of their patients. This assistance shall not take the form of competitive practice.

"RESOLVED FURTHER, That the Board of Regents shall, and it does hereby, direct that the primary purpose of the Eugene Talmadge Memorial Hospital shall be to serve as an auxiliary of the Medical College of Georgia in the development of medical knowledge and skills through organized programs of teaching. The development of such knowledge and skills is, of necessity, dependent upon the proficiencies developed while engaged in the care of patients under proper supervision and in observing and participating in medical research programs.

"RESOLVED FURTHER, That the Board of Regents shall, and it does hereby, authorize and direct that the services of the Eugene Talmadge Memorial Hospital of the Medical College of Georgia be available upon the request of physicians or a medical agency—such as governmental agencies (such as the Board of Health and Vocational Rehabilitation Department), and voluntary agencies (such as the Foundation for Infantile Paralysis, Georgia Heart Association and similar organizations)—responsible for the care of patients, and that such services be used to supplement services available in the patient's home community. The Board requests physicians and such agencies to send only those patients to the Eugene Talmadge Memorial Hospital who are of teaching interest or who need services that are not available in their local communities.

"RESOLVED FURTHER, That the Board of Regents shall, and it does hereby, direct that there be no private diagnostic clinic operated in connection with the Medical College of Georgia and that no patients be admitted to the hospital, except on referral from a physician or an agency as hereinbefore stated.

"RESOLVED FURTHER, That the Board of Regents shall, and it does hereby, authorize and direct the President of the Medical College of Georgia to make every effort to see that present State medical programs, which are being conducted through local hospitals, clinics and centers, are continued locally with the Medical College offering the facilities of its hospital to the people of Georgia through their physicians for those problems which cannot be handled in the local community.

"RESOLVED FURTHER, That the Board of Regents shall, and it does hereby, direct the teaching program of the Medical College of Georgia to be developed and carried on primarily through a full-time faculty.

"RESOLVED FURTHER, That the Board of Regents shall, and it does hereby, direct that no individual shall personally receive pecuniary profit from the admission of a patient to the Eugene Talmadge Memorial Hospital and therefore directs the Medical College of Georgia to operate the Eugene Talmadge Memorial Hospital with a closed staff that shall be composed only of the full-time and part-time faculty members of the Medical College of Georgia.

"RESOLVED FURTHER, That the Board of Regents shall, and it does hereby, authorize the President of the Medical College of Georgia to negotiate a yearly contract between the members of the full-time and part-time faculty whereby medical services shall be provided for all patients in the Eugene Talmadge Memorial Hospital. This contract shall provide that the members of the full-time and part-time faculty shall agree to render, for a stipulated salary, medical services to all patients subject to the statutes of the Medical College of Georgia. The contract shall provide further that a faculty member shall donate all fees for professional services rendered patients of the Hospital to a fund to be held by the comptroller of the Medical College as hereinafter provided. The Board of Regents directs that the Medical College of Georgia shall not permit the exploitation of the services of the faculty for the financial profit of either the Medical College or the Hospital, nor cause deterioration of the medical services rendered.

"RESOLVED FURTHER, That the Board of Regents shall, and it does hereby, direct that patients of the Eugene Talmadge Memorial Hospital who are medically indigent, but able to pay in part or in full for the cost of hospital service, shall reimburse the Hospital in an amount commensurate with their ability to pay. Income, dependency and insurance shall be taken into consideration in determining the charges that are made for such services. Institutions and organizations for mutual benefit or for accident, sickness and life insurance for analagous purposes shall meet such costs as are covered by the contract under which the service is rendered. Money collected for hospital service shall become a part of the budget of the Eugene Talmadge Memorial Hospital for defraying the costs of hospitalization.

This action is taken by the Board because it recognizes the fact that illness is no respecter of persons, that medical problems will present themselves to all classes of persons, and that requests will be made for the admission of patients to the Hospital whose economic conditions will vary from the completely indigent to the patient who is able to pay for complete service. It is the belief of the Board that it was not the intention of the General Assembly of the State of Georgia to provide a hospital with free care for those patients who are able to pay.

“RESOLVED FURTHER, That the Board of Regents shall, and it does hereby, direct faculty members providing professional services to patients of the Hospital to determine the charges for such services and to inform the chairmen of their respective departments at the Medical College of Georgia of the charges. These charges shall be commensurate with the fees of the medical profession in the Augusta area. The Board directs the chairmen of the departments of the Medical College to submit statements of these charges for professional services through the comptroller of the Medical College to those patients receiving the professional services who are able to pay. The fees shall be paid to the comptroller of the Medical College of Georgia who shall hold them in a special fund. Expenditures from this fund shall be made only upon direction from the Board of Regents. The Board declares that this special fund shall not be used to compensate members of the faculty for their duties in the care of the patients at the Eugene Talmadge Memorial Hospital or for their administrative and instructional duties at the Medical College of Georgia.”

The foregoing resolution was unanimously adopted by the Board of Regents at its meeting on March 9, 1955.

Reference Committee recommendation—Reference Committee No. 3 recommends to the House of Delegates that the Report of the Study Committee of the Eugene Talmadge Memorial Hospital be accepted for information only. (See Reference Committee Recommendation concerning Talmadge Memorial Hospital under Report of Council on page 289.)

House of Delegates Action—Recommended adoption of the reference committee recommendation to accept this report for information only which was moved, seconded, and adopted.

Advisory Committee of the Eugene Talmadge Memorial Hospital
J. C. Metts, Chairman

The Advisory Committee of the Eugene Talmadge Memorial Hospital met with the Study Committee, previously appointed for the same purpose, on the evening of January 8th and the forenoon of January 9th. The purpose of this meeting was to attempt to find a solution which would be ethically acceptable to the physicians and the Medical College of Georgia in regard to the admission of pay patients to the Eugene Talmadge Memorial Hospital. Recommendations had been previously prepared, and these were submitted at a joint meeting of the two groups. A very great deal of discussion by various members and visiting physicians followed. A revised recommendation was submitted to Dr. Pund to be transmitted to the Board of Regents to determine its legality only. This was duly forwarded to Dr. Pund, and acknowledgement of its receipts and transmissal received.

Reference Committee recommendation—Reference Committee No. 3 recommends to the House of Delegates that the Report of the Advisory Committee of the Eugene Talmadge Memorial Hospital be accepted for information only. (See reference committee recom-

mendation concerning the Talmadge Memorial Hospital under Report of Council on page 289.)

House of Delegates action Recommended adoption of the reference committee recommendation to accept this report for information only which was moved, seconded, and adopted.

Council of the MAG
H. L. Cheves, Chairman

The Council of the Medical Association of Georgia met quarterly as stipulated in the MAG Constitution and By-Laws. Meetings were held on the following dates: May 5, 1954, Macon; June 5-6, 1954, Atlanta; September 19, 1954, Atlanta; November 4, 1954, Atlanta; December 11-12, 1954, Macon; March 12-13, 1955, Augusta, and May 1, 1955, Augusta.

The Executive Committee of Council met July 11, 1954, Augusta; February 4, 1955, Telephone Conference; thus far this year.

All matters of Association business considered or acted upon by Council has been recorded in the following issues of the *Journal of the Medical Association of Georgia*: June 1954, July 1954, August 1954, November 1954, December 1954, January 1955 and April 1955.

Council Committee on Auditing and Appropriations
J. W. Chambers, Chairman

I am happy to report to Council for the Auditing and Appropriations Committee for the year 1954 that the Medical Association of Georgia operated within its approved budget for the fiscal year of 1954 with the exception of items specifically approved by Council which were of a nature that could not be foreseen, and that these items were by and large minimal. The annual audit of the Association's books has just been released and time for a complete study by this committee at this writing is not available. This will be done before the next meeting of Council and a detailed report given to that body at that time. I can report at this time that the Association operated during the year and accumulated a net gain of approximately \$11,500.00 after taking care of its operating expenses. This gives us a modest operating reserve as contrasted to 1953 of practically none.

The budget as submitted by this committee for operations for 1955 was approved by Council at its December 1954 meeting, and copies of this budget are in the hands of the members of Council; and it was published in the January issue of the *Journal*.

I am glad to report that this committee has worked harmoniously during the year, and its decisions and recommendations have been unanimous. For this I express my sincere thanks to the other members. I also wish to express our sincere thanks to the headquarters personnel for their generous cooperation.

Membership By Districts

Districts	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
First	202	171	196	165
Second	166	110	167	107
Third	187	146	177	145
Fourth	153	109	150	108
Fifth	875	681	870	627
Sixth	219	163	206	156
Seventh	224	164	204	148
Eighth	160	135	154	128
Ninth	130	93	122	89
Tenth	305	234	292	220
Total	2621	2006	2538	1895

Attendance at Council Meetings*

Councilors	May 5	June 5-6	Sept. 19	Nov. 4	Dec. 11-12	Mar. 12-13	
Peter B. Wright	*	*	*	*	*	*	100%
H. Dawson Allen, Jr.	*	*	0	*	*	*	
David Henry Poer	*	*	*	*	*	*	100%
William Harbin	*	0	*	0	*	0	
Lee Howard (1st)	0	*	*	0	*	*	
Geo. R. Dillinger (2nd)	*	*	*	*	*	0	
W. G. Elliott (3rd)	*	*	*	*	*	*	100%
J. W. Chambers (4th)	*	*	*	*	*	*	100%
Mark S. Dougherty, Jr. (5th)	*	*	*	*	0	0	
H. Dawson Allen and Henry Tift (6th)	*	*	0	*	*	*	
D. Lloyd Wood (7th)	*	*	*	*	*	*	100%
Neal F. Yeomans (8th)	*	*	*	*	*	*	100%
W. Bruce Schaefer (9th)	*	0	*	0	*	*	
H. L. Cheves (10th)	*	*	*	*	0	*	
Charles T. Brown (1st)	0	0	*	*	0	0	
Carl S. Pittman, Sr. (2nd)	*	*	*	*	0	*	
Guy J. Dillard (3rd)	0	0	0	0	0	0	
Clarence B. Palmer (4th)	*	*	*	0	0	*	
J. G. McDaniel (5th)	*	*	*	*	*	*	100%
H. G. Weaver (6th)	0	0	0	0	*	0	
Ralph W. Fowler (7th)	0	0	*	*	*	*	
James M. Hicks (8th)	0	0	*	*	0	0	
Chas. R. Andrews, Jr. (9th)	0	*	0	*	*	*	
J. Victor Roule (10th)	0	0	0	0	0	0	

*—means present at meeting.

0—means absent from meeting.

Addendum

The Richmond County Medical Society, upon the request of Council, respectfully submits to the House of Delegates of the Medical Association of Georgia the following resolution concerning the operational policies of the Eugene Talmadge Memorial Hospital. Much in the resolution is taken verbatim from that passed by the Board of Regents on March 9, 1955. In other respects it departs from the above resolution to embody certain changes asked for by the House of Delegates of the Medical Association of Georgia in a called meeting in Macon in December 1954. Furthermore, this plan conforms to that submitted by the study committee appointed by the House of Delegates at this December meeting and also approved by the advisory board of the Medical Association of Georgia, with two exceptions. These two exceptions are: (1.) that only indigent and semi-indigent patients be admitted to the Eugene Talmadge Memorial Hospital, and (2.) that full time faculty members not be given the privilege of referral practice in the Eugene Talmadge Memorial Hospital and no practice or consultation privileges outside except as hereinafter provided.

These two changes are proposed for the following reasons:

(1.) it would relieve the full-time faculty members of any stigma of unethical practice of medicine, and

(2.) it is understood from verbal information that the Attorney General's Office has declared it unconstitutional for a full-time state employee to receive fees from other gainful employment.

The House of Delegates of the Medical Association of Georgia appreciates the efforts of the Board of Regents in behalf of medical education in the state and in behalf of the sick people of the State of Georgia. We

stand ready to give our full cooperation in working out this problem.

It is respectfully requested that the Board of Regents of the University System of Georgia give careful consideration to the following resolutions:

RESOLVED, that the House of Delegates of the Medical Association of Georgia respectfully asks the Board of Regents of the University System of Georgia to declare the following to be the operational policies of the Eugene Talmadge Memorial Hospital.

1. That there shall be the development of a strong center for medical education at the Medical College of Georgia. That the declaration of this policy places an obligation upon the Medical College to furnish services requested by physicians which will aid in the diagnosis and treatment of their patients, and that this assistance shall not take the form of competitive practice.

2. That the primary purpose of the Eugene Talmadge Memorial Hospital shall be to serve as an auxiliary of the Medical College of Georgia in the development of such knowledge and skills is, of necessity, dependent upon the proficiencies developed while engaged in the care of patients under proper supervision and in observing and participating in medical research programs.

3. That the services of the Eugene Talmadge Memorial Hospital be available upon the request of physicians or a medical agency—such as governmental agencies (such as the Board of Health and Vocational Rehabilitation Department) and voluntary agencies (such as the Foundation for Infantile Paralysis, Georgia Heart Association, and similar organizations)—responsible for the care of patients, and that such services be used to complement services available in the patient's home community. That the board request physicians and such agencies to send only those patients to the Eugene Talmadge Memorial Hospital who are of teaching interest or who need services that are not available in their local communities.

4. That there shall be no private diagnostic clinic operated in connection with the Medical College of Georgia and that no patients be admitted to the hospital except on referral from a physician or an agency as hereinbefore stated.

5. That the President of the Medical College of Georgia make every effort to see that present state medical programs, which are being conducted through local hospitals, clinics, and centers, are continued locally with the Medical College offering the facilities of its hospital to the people of Georgia through their physicians for those problems which cannot be handled in the local community.

6. That the teaching programs of the Medical College of Georgia be developed and carried on through a full-time faculty of key administrative men. This full-time faculty will be allowed no referral practice in the Eugene Talmadge Memorial Hospital and no consultation privileges in other hospitals except state and federal hospitals. These activities of the full-time faculty are to be limited by the President of the Medical College of Georgia in such a way as to assure that proper teaching and research duties are not neglected.

7. That the Medical College of Georgia will have a part-time faculty who will do a part of the teaching and also participate in the research program. That the part-time faculty members will not have the privilege of having pay patients in the hospital.

8. That no individual shall personally receive pecuniary profit from the admission of a patient to the Eugene Talmadge Memorial Hospital and therefore that the Medical College of Georgia be directed to operate the Eugene Talmadge Memorial Hospital with a closed staff which shall be composed only of the full-time and part-time faculty members of the Medical College of Georgia.

9. That the President of the Medical College negotiate a yearly contract between members of the full-time and part-time faculty whereby medical services shall be provided for all patients in the Eugene Talmadge Memorial Hospital. This contract shall provide that the members of the full-time and part-time faculty shall agree to render, for a stipulated salary, medical services to all patients subject to the statutes of the Medical College of Georgia. The Medical College of Georgia shall not permit the exploitation of the services of the faculty for the financial profit of either the medical college or the hospital, nor cause deterioration of the medical services rendered.

10. That only indigent or medically indigent (staff pay) patients shall be admitted to the Eugene Talmadge Memorial Hospital except in case of an emergency or unusual circumstances, and that no fee for professional services as such be rendered or collected from patients in this institution.

11. That patients of the Eugene Talmadge Memorial Hospital who are medically indigent but able to pay in part or in full for the cost of hospital service shall reimburse the hospital in an amount commensurate with their ability to pay. Income, dependents, and insurance shall be taken into consideration in determining the charges that are made for such services. Institutions and organizations for mutual benefit or for accident, sickness and life insurance for analogous purposes shall meet such costs as are covered by the contract under which the service is rendered. Money collected for hospital service shall become a part of the budget of the Eugene Talmadge Memorial Hospital for defraying the costs of hospitalization.

That it is the belief of the board that it was not the intention of the General Assembly of the State of Georgia to provide a hospital with free care for those patients who are able to pay.

12. That patients admitted to the Eugene Talmadge Memorial Hospital be referred to the proper service in the hospital. All patients in the Eugene Talmadge Memorial Hospital will be considered teaching patients.

13. That the operation of the Eugene Talmadge Memorial Hospital shall be under the continual observation and counsel of the Board of Regents and its Medical Advisory Committee. This Medical Advisory Committee shall be composed of one member from each of the medical society districts of Georgia. Each district medical society shall submit to the Board of Regents the names of two of its members, one of which shall be selected by the Board of Regents.

Reference Committee Recommendation—Reference Committee No. 3 recommends that, in lieu of the report of the Eugene Talmadge Memorial Hospital Study Committee and the Eugene Talmadge Memorial Hospital Advisory Committee report which were received for information only, the following substitute resolution be adopted: "This resolution is identical with the mimeographed resolution dated April 26, 1955, submitted by Richmond County Medical Society upon request of the Council of the Medical Association of Georgia to the Council of the Medical Association of Georgia, and in turn, made an addendum to the Council report. There are several minor changes and these changes, the committee

felt, would correct certain stated objections."

The House of Delegates of the Medical Association of Georgia appreciates the effort of the Board of Regents in behalf of medical education in the state and in behalf of the sick people in the State of Georgia. The Medical Association of Georgia stands ready to give its full cooperation in working out this problem.

It is respectfully requested that the Board of Regents of the University System of Georgia give careful consideration to the following resolution:

RESOLVED, that the House of Delegates of the Medical Association of Georgia respectfully ask the Board of Regents of the University System of Georgia to declare the following to be the operational policies of the Eugene Talmadge Memorial Hospital:

1. That there shall be the development of a strong center for medical education at the Medical College of Georgia. That the declaration of this policy places an obligation upon the Medical College of Georgia to furnish services requested by physicians which will aid in the diagnosis and treatment of their patients, and that this assistance shall not take the form of private practice.

2. That the primary purpose of the Eugene Talmadge Memorial Hospital shall be to serve as an auxiliary of the Medical College of Georgia in the development of medical knowledge and skills through organized programs of teaching. The development of such knowledge and skills is, of necessity, dependent upon the proficiencies developed while engaged in the care of patients under proper supervision and in observing and participating in medical research programs.

3. That the services of the Eugene Talmadge Memorial Hospital be available upon the request of physicians or a medical agency—such as governmental agencies (such as the Board of Health and Vocational Rehabilitation Department) and voluntary agencies (such as the Foundation for Infantile Paralysis, Georgia Heart Association, and similar organizations)—responsible for the care of patients, and that such services be used to complement services available in the patient's home community. That the Board of Regents request physicians and such agencies to send only those patients to the Eugene Talmadge Memorial Hospital who are of teaching interest or who need services that are not available in their local communities.

4. That there shall be no private diagnostic clinic operated in connection with the Medical College of Georgia and that no patients be admitted to the hospital except on referral from a physician or an agency as hereinbefore stated.

5. That the President of the Medical College of Georgia make every effort to see that present state medical programs, which are being conducted through local hospitals, clinics, and centers, are continued locally with the Medical College offering the facilities of its hospital to the people of Georgia through their physicians for those problems which cannot be handled in the local community.

6. That the teaching programs of the Medical College of Georgia be developed and carried on through a full-time faculty of key administrative men. This full-time faculty will be allowed no referral practice in the Eugene Talmadge Memorial Hospital and no pay consultation privileges in other hospitals except state and federal hospitals. These activities of the full-time faculty are to be limited by the President of the Medical College of Georgia in such a way as to assure that proper teaching and research duties are not neglected.

7. That the Medical College of Georgia will have a part-time faculty who will do a part of the teaching and also participate in the research program. That the part-time faculty members will not have the privilege of having pay patients in the hospital.

8. That no individual shall receive pecuniary profit from the admission of a patient to the Eugene Talmadge Memorial Hospital and the Medical College of Georgia shall be directed to operate the Eugene Talmadge Memorial Hospital with a closed staff that shall be composed only of the full-time and part-time faculty members of the Medical College of Georgia.

9. That the President of the Medical College negotiate a yearly contract between members of the full-time and part-time faculty whereby medical services shall be provided for all patients in the Eugene Talmadge Memorial Hospital. This contract shall provide that the members of the full-time and part-time faculty shall agree to render, for a stipulated salary, medical services to all patients subject to the statutes of the Medical College of Georgia. The Medical College of Georgia shall not permit the exploitation of the services of the faculty for the financial profit of either the medical college or the hospital, nor cause deterioration of the medical services rendered.

10. That only indigent or medically indigent (staff pay) patients shall be admitted to the Eugene Talmadge Memorial Hospital except in case of an emergency or unusual circumstances, and that

no fee for professional services be rendered or collected from patients in this institution.

11. That patients of the Eugene Talmadge Memorial Hospital who are medically indigent but able to pay in part or in full for the cost of hospital service shall reimburse the hospital in an amount commensurate with their ability to pay. Income, dependents, and insurance shall be taken into consideration in determining the charges that are made for such services. Institutions and organizations for mutual benefit or for accident, sickness, and life insurance for analogous purposes shall meet such costs as are covered by the contract under which the service is rendered. Money collected for hospital service shall become a part of the budget of the Eugene Talmadge Memorial Hospital for defraying the costs of hospitalization.

That it is the belief of the board that it was not the intention of the General Assembly of the State of Georgia to provide a hospital with free care for those patients who are able to pay.

12. That patients admitted to the Eugene Talmadge Memorial Hospital be referred to the proper service in the hospital. All patients in the Eugene Talmadge Memorial Hospital will be considered teaching patients.

13. That the operation of the Eugene Talmadge Memorial Hospital shall be under the continual observation and counsel of the Board of Regents and its Medical Advisory Committee. This Medical Advisory Committee shall be composed of one member from each of the medical society districts of Georgia. Each district medical society shall submit to the Board of Regents the names of two of its members, one of which shall be selected by the Board of Regents. This committee shall be a standing (continuous) committee. Members of the committee shall be appointed for a term of three years or more. The first year the members of the committee will be appointed for staggered terms of office.

The reference committee further recommends the following resolution which pertains to the resolution submitted by Council concerning the Eugene Talmadge Memorial Hospital:

RESOLVED, that the President of the Medical Association of Georgia, with the approval of Council, appoint a committee of approximately three to five members, who are familiar with the discussion carried out by the reference committee, to present in person the resolution adopted concerning the Eugene Talmadge Memorial Hospital to the Board of Regents.

It was recognized by Reference Committee No. 3 that the Richmond County Medical Society has been in the midst of one of the most difficult problems to face any medical society in the Medical Association of Georgia in recent years. These difficulties have aroused great interest and, sometimes, strong feeling among members of the profession throughout the state, the general public, the Board of Regents, and others.

BE IT RESOLVED, THEREFORE, that the Richmond County Medical Society and that the Medical Association of Georgia Study Committee and the Advisory Committee of the Eugene Talmadge Memorial Hospital, respectively, be given a vote of thanks by the assembled delegates of the Medical Association of Georgia, for the statesmanlike manner in which they have dealt with the problem. That the resolutions presented are constructive and do credit to the Medical Association of Georgia, and will benefit the people of Georgia and the Medical College of Georgia.

House of Delegates Action—Enoch Callaway, LaGrange, moved that the words "health agencies" be stricken from the resolution as presented by the reference committee. D. Lloyd Wood supported this motion. The motion was approved. John W. Turner, Atlanta, asked that in the terminology of the resolution as presented by Reference Committee No. 3 the wording, that "This Committee shall be appointed for a term of three years," should be changed to read, "That the individual members of this committee shall be appointed for terms of three years." This motion of Dr. Turner's was seconded and approved.

The Report of Council, including the Audit and Appropriations Committee Report and the Addendum concerning the Eugene Talmadge Memorial Hospital was approved as presented by the reference committee and was so adopted. (This action precedes any earlier action taken on the operational policies of the Eugene Talmadge Memorial Hospital.)

Resolution on Honorary Membership (John R. Fowler, M.D.)

Introduced by Fred H. Simonton, Chickamauga

WHEREAS, John R. Fowler, M.D., a native of South Carolina and a graduate of Medical College of Georgia, class of 1914, now lives in Barre, Massachusetts, where

he is engaged in general practice of medicine, and is president of the American Academy of General Practice,

NOW THEREFORE, BE IT RESOLVED, that he be elected to honorary membership in the Medical Association of Georgia by the House of Delegates.

Reference Committee recommendation—That the resolution concerning honorary membership for John R. Fowler, M.D., Barre, Massachusetts, President of the American Academy of General Practice, be approved as submitted.

House of Delegates action—Recommended adoption of the Resolution on Honorary Membership for John R. Fowler, M.D., as presented by the reference committee, which was moved, seconded, and adopted.

Resolution on Honorary Membership (Daniel Collier Elkin, M.D.)

Introduced by B. L. Shackelford, Atlanta

WHEREAS, The Fulton County Medical Society in regular session on December 1, 1954, nominated a distinguished member for honorary membership in the Association; and,

WHEREAS, this distinguished physician, a member of the Association for 32 years, has removed his residence from the State of Georgia; and,

WHEREAS, this distinguished physician has served as Professor of Surgery at Emory University School of Medicine from 1930 to 1954, and is the recipient of the Matas Medal for Vascular Surgery and the Hardman Cup Award, presented by the Medical Association of Georgia, and has received numerous honors throughout his long and outstanding career in the profession.

NOW THEREFORE, BE IT RESOLVED BY THE HOUSE OF DELEGATES OF THE MEDICAL ASSOCIATION OF GEORGIA, that Daniel Collier Elkin be awarded Honorary Membership in the Association.

Reference Committee recommendation—Reference Committee No. 3 approves the Resolution on Honorary Membership for Daniel Collier Elkin as presented by the Fulton County Delegation.

House of Delegates action—Recommended adoption of the Resolution on Honorary Membership for Daniel Collier Elkin as presented by the reference committee, which was moved, seconded, and adopted.

REFERENCE COMMITTEE NO. 4

James Green, Acting Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it by the House of Delegates.) Members of the committee present at the reference committee meeting are as follows: Jams A. Green, acting chairman; Linton H. Bishop, Jr.; Rudolph F. Bell, H. B. Cason, C. S. Pittman, Jr., John Leslie, A. G. LeRoy, and Virgil Williams.

First Vice-President Willard R. Golsan

The office of First Vice-President of the Medical Association of Georgia is strictly an honorary office given to the General Chairman of the Annual Session of the organization. Being such an office, it carries no responsibility and little incentive for the officer to work.

It is felt this office should be made more important, to carry fitting responsibility and to encourage more work.

With these thoughts in mind, the following recommendations are made:

1. That beginning with the 1957 convention, the custom of electing the General Chairman of the Annual Session to be First Vice-President of the Medical Association of Georgia be discontinued. Instead of this custom, it is suggested the First Vice-President be elected in the same manner as the President-Elect, with the idea of the First Vice-President's being considered as a possible President-Elect the following year. This would add considerable dignity and importance to the office.

2. That the First Vice-President be instructed to attend all important policy-making meetings, with the President, so that the First Vice-President will be kept up to date at all times on all important policy matters, so if it should become necessary for the First Vice-President to relieve the President he would be thoroughly familiar with the affairs of the Association.

3. That the First Vice-President should be assigned specific duties which would encourage incentive to work and designate responsibility.

It is suggested one of these duties be to visit various local societies, giving him a chance to study and learn their problems, thus helping the State Association iron out differences of opinion and creating closer harmony between the state association and the local societies.

Reference Committee recommendation—Reference Committee No. 4 disapproves the recommendation No. 1 of the first vice-president, but is heartily in favor of the vice-presidents' assuming their obligations and duties as outlined in recommendations No. 2 and No. 3 of the First Vice-President's Report.

House of Delegates action—Recommended adoption of the reference committee recommendation concerning the First Vice-President's Report, which was moved, seconded, and adopted.

Second Vice-President

Milford B. Hatcher

It is felt that the offices of the vice-presidents of the Medical Association of Georgia are not being used for the highest efficiency and advantage to the Association.

It is felt that these officers could relieve the president and secretary-treasurer of some of their traveling and visitation of the district and county societies. A schedule should be prepared at the beginning of their terms of office and up-to-the-minute information given them so that they can bring official and authoritative material concerning the Association's affairs and the policies as set out by the Council.

They should render a report of their visits, noting particularly the problems of the local societies, the amount of interest, and the progress of the local societies.

This officer has discussed the above freely with the first vice-president, and he is definitely of the same opinion as the first vice-president as regards utilization of the first vice-president as a potential president-elect. It is felt that this would allow the individual if he should become president of the Association to have a considerable amount of background for his office. Thus, I wish to second the report of the first vice-president.

Reference Committee recommendation—The committee recommends that the Report of the Second Vice-President be handled as the Report of the First Vice-President in intent and in manner.

House of Delegates action—Recommended the adoption of the reference committee recommendation concerning the Second Vice-

President's Report as presented by the reference committee, which was moved, seconded, and adopted.

AMA Delegates

C. H. Richardson, Sr., Chairman

Eustace A. Allen

Spencer A. Kirkland

Since the last session of the Medical Association of Georgia, we have had two meetings of the House of Delegates, American Medical Association, one in San Francisco and one in Miami. A brief report of each meeting follows:

Total registration for the San Francisco meeting was approximately 35,000, including more than 12,000 physicians. There were about 90 resolutions considered; fee splitting, osteopathy, closed panel medical care plans, veterans medical care and the training of foreign medical school graduates were among the major subjects taken up by the House of Delegates.

Highlights of the opening House on Monday were the selection of Dr. W. W. Babcock, of Philadelphia, to receive the Distinguished Service Award for his outstanding contribution to medicine and humanity, and the addresses of Dr. Edward J. McCormick, of Toledo, then president of the Association and Dr. Walter B. Martin, Norfolk.

The House adopted a supplementary report of the Reference Committee on Miscellaneous Business which recommended acceptance of the Judicial Council report on the subject of billing and made the additional recommendation that the House of Delegates resolve that it firmly opposes fee splitting, rebating or payment of commission in any guise whatsoever, and that it further opposes any mechanism that encourages this practice.

The Judicial Council was of the opinion that when two or more physicians render services to one patient, they should render separate bills. There are cases however, where the patient may make a special request to one of the physicians attending him, that one bill be rendered for the entire services. Should this occur, it is considered ethical if the physician from whom the bill is requested, renders an itemized statement setting forth the services rendered by each physician and the fee charged. This should be paid directly to the individual physician who rendered the service in question.

Several resolutions dealing with the osteopathic problem were considered. The House accepted a recommendation by the Reference Committee on Medical Education and Hospitals and adopted a supplementary report of the Board of Trustees on a report of the committee for the study of relations between osteopathy and medicine. It was concluded that final action on this matter be deferred until December, 1954.

Closed Panel Plans—The much publicized New York Resolution, calling for several changes in the principles of medical ethics relative to participation in closed panel medical care plans was considered by the Reference Committee on Miscellaneous Business. That committee made the following recommendations which were adopted by the House:

The Judicial Council has jurisdiction on all questions on medical ethics, therefore it is recommended that the House of Delegates request the Judicial Council to—investigate the relations of physicians to prepaid medical care plans and render such interpretations of the *Principles of Medical Ethics* as the Council deems necessary and report to the House of Delegates not later than the next annual meeting of the Association.

Veterans Medical Care—Accepting a report by the Reference Committee on Legislation and Public Relations the House adopted two strong resolutions condemning the present practice of establishing service connection for veterans disabilities by legislative sanction.

Foreign Medical Graduates—It was agreed that this matter could be best met by referring the entire problem to the Council on Medical Education and Hospitals for further study and report results of such study at the interim session in 1954.

Registration of Hospitals—The House also approved a Board of Trustees report calling for discontinuation of the registration of hospitals by the Council on Medical Education and Hospitals, and suggesting that the Joint Commission on the Accreditation of Hospitals be requested to undertake the registration of hospitals in addition to its present accreditation activities.

Miscellaneous—Among a wide variety of other actions, the House also voted to continue to hold annual clinical meetings, to establish a program of medical military scholarships with appropriate safeguards, to extend, on a voluntary basis, the medical education program for national defense which currently is in operation in five medical schools as a pilot study, and to authorize the Council on Scientific Assembly to conduct a thorough study of the use of tape recordings of the material presented at such meetings of the Council and it asked for a report at the December meeting.

Special Citations—Two special citations were presented by the Association during the San Francisco meeting. During the Presidential Inauguration Ceremony, Dr. McCormick presented an award to a fellow Toledoan, Dr. Nicholas Dallis, for his outstanding service as the writing member of the team that produces the comic strip "Rex Morgan M.D." At the closing House session on Thursday, Dr. Martin presented a special citation to Smith, Kline and French Laboratories of Philadelphia, for "pioneering use of television in bettering the health of the nation." The plaque was accepted for the company by Mr. Francis Boyer, the president of the company.

The closing also brought the announcement that the California Medical Association had presented a check for \$10,000 to the American Medical Education Foundation.

Election of Officers—Results of the election at the closing session were as follows: Dr. Elmer Hess, Erie, Pa., president-elect; Dr. Clark Bailey, Harlan, Ky., vice-president; Dr. J. J. Moore, Chicago, Ill., treasurer; Dr. James R. Reuling, Bayside, N. Y., speaker of the House of Delegates; Dr. Vincent Askey, Los Angeles, vice-speaker, Dr. David B. Allman, Atlantic City, and Dr. F. J. Blasingame of Wharton, Texas, were re-elected to their positions on the Board of Trustees.

Also reelected was Dr. George F. Lull of Chicago, secretary.

The House of Delegates chose New York City as the place for the 1957 annual meeting, San Francisco for 1958 and Atlantic City for 1959. The 1955 meeting was previously scheduled to be held in Atlantic City June 6-10th, and the 1956 meeting in Chicago.

The House of Delegates of the American Medical Association's Eighth Clinical Meeting, met at the McAllister Hotel, Miami, November 29 to December 2, 1954, at which time 189 Delegates were seated. The total attendance was 7,500 which included residents,

interns, nurses, exhibitors and guests. Of that number 3,167 were physicians.

Among the major subjects of discussion at this meeting were geriatrics, medical ethics, internships, grievance committees, hospital accreditation, osteopathy, the Doctor Draft Law, state subsidized medicine and the malpractice insurance problems.

Dr. Karl B. Pace of Greenville, N. C., was named the "1954 General Practitioner of the Year." The medal and citation were presented to Dr. Pace by Dr. W. B. Martin, Norfolk, Virginia, President of the AMA.

Highlights of the opening session were addresses by AMA President Martin; Mr. Seaborn P. Collins, National Commander of the American Legion; Mrs. Overta Culp Hobby, Secretary of the Department of Health, Education and Welfare; and Dr. Edwin J. Faulkner, President of the Woodman Accident and Life Insurance Company of Lincoln, Nebraska.

Mr. Collins told the House that he was willing to appoint qualified Legion representatives to take part in a joint Legion-AMA study of veterans' hospitalization. Later, the Board of Trustees announced the appointment of a three member committee to meet with the Legion on the issue of veterans' medical care. Members of this committee are Dr. Elmer Hess, Dr. Louis Orr and Dr. David Allman.

Mrs. Hobby, in presenting the Eisenhower Administration's Health Reinsurance Proposal, said, "The health reinsurance proposal represents what we believe to be a necessity, it offers opportunity for self-help without subsidy."

Mr. Faulkner expressed the opinion that the reinsurance program "would be foredoomed to disappoint its proponents." He declared, "Voluntary health insurance can bring satisfactory protection to practically all of the people without a federal reinsurance program."

The Board of Trustees announced the appointment of a 13 member commission to make a comprehensive survey of the various types and plans through which the American people receive medical services. This commission, headed by Dr. Leonard W. Larson of Bismark, N. D., a member of the Board of Trustees, will begin work immediately and will require at least a year to complete its survey.

New A.M.A. Geriatrics Unit—The House of Delegates passed a Pennsylvania resolution which directed that the A.M.A. Board of Trustees consider the creation of an organization on geriatrics within the present structure of the Association, the purpose of which shall be (1) to develop and assist committees on geriatrics and gerontology originating from constituent state associations and component societies of the A.M.A.; (2) to act as a liaison between such state and county committees so there will be a free flow of information between all levels of organized medicine on the subject of geriatrics; (3) to make available to the American people such facts, data and opinions concerning the subject of geriatrics as may be considered of value in alleviating social and medical problems created by the increasing population of older age groups; (4) to perform such other duties as will improve and advance the medical care rendered to people of the older age group.

Medical Ethics—Accepting a recommendation in a report of the Council on Constitution and By-laws, the House amended Section 7 of chapter 1—of the *Principles of Medical Ethics* so that it now reads as follows on the subject of patents and copyrights:

"A physician may patent surgical instruments, appliances and medicines or copyright publications, methods and procedures. The use of such patents or copyrights or the receipt of remuneration from them which retards or inhibits research or restricts the benefits derivable therefrom is unethical."

Report on Internships—The Committee on Internships is of the opinion that graduates of foreign medical schools should be considered for intern appointment in approved hospitals only when there is satisfactory evidence that: (1) language difficulties will not seriously impair the program, (2) the same educational standards are applied to graduates of foreign schools as to graduates of approved American medical colleges and (3) the appropriate state licensing board approves.

The committee believes that the present standards detailing only the number of annual admissions, autopsy rate, number of beds and assignment of an intern to from 15 to 25 beds, are without significant meaning unless and until every local situation is reviewed on the grounds and with full opportunity for discussion between the representative of the accrediting body and representatives of the hospitals governing board and its medical staff.

Grievance Committee—In order to improve efficiency and maintain high standards in the operation of grievance or mediation committees, the House endorsed the principles of two similar resolutions introduced by the Colorado and Mississippi delegations and asked the Board of Trustees to appoint a committee to study and report on recommended standards for the operation of such services.

Hospital Accreditation—In place of an Indiana resolution protesting certain situations arising in connection with hospital inspections, the House adopted the following substitute resolution:

"Resolved, that the secretary of the A.M.A., be directed to request that the Joint Commission on the Accreditation of Hospitals supply a copy of the letter of notification regarding the results of the survey of each hospital to the hospital administrator to the chief of the medical staff and to the chairman of the governing board of the hospital."

Osteopathy—The House concurred in the following supplementary report of the Board of Trustees on the osteopathic situation:

"Contingent on the receipt of the report from the committee to study the relations between osteopathy and medicine of its 'on campus' observations of osteopathic schools, the House of Delegates in June, 1954, agreed to hold in abeyance any action on this important subject until this meeting.

"The committee, after meetings and extensive negotiations with the American Osteopathic Association, has now made final arrangements for visiting five of the six schools of osteopathy, and these plans have been approved by the Board of Trustees.

"It is the recommendation of the Board, therefore, that consideration of this matter be held in abeyance by the House of Delegates until the June 1955 meeting, at which time the committee expects to have a complete report of its findings concerning the nature, scope and quality of education in schools of osteopathy."

The Doctor Draft Law—The Reference Committee on Medical Military Affairs considered several reports and resolutions involving the Doctor Draft Law and then pro-

posed the following policy statement which was adopted by the House of Delegates:

"(A) That on the basis of current information, the House of Delegates commend and express itself as being in complete accord with the Board of Trustees and its Council on National Defense, that the Doctor Draft Law should not be extended after June 30th, 1955, and that the House of Delegates further express its confidence in the ability of the Board of Trustees and its Council on National Defense to properly handle any new situation which may develop in regard to this highly complex and involved problem.

"(B) That the Board of Trustees and its Council on National Defense continue to study the problem of providing the best possible medical service for members of the armed forces and that they make recommendations to the Department of Defense at the earliest possible time for a more permanent solution to the problem, giving especial attention to the further development of a Career Medical Corps with adequate compensation therefor."

State Subsidized Medicine—Most controversial issue at the Miami meeting was a resolution on "Policy on Medical Practice by Tax Supported Medical Schools", introduced by the Mississippi State Medical Association. This resolution provided that:

"The American Medical Association reaffirm its unalterable opposition to Socialized Medicine regardless of the form it may assume.

"The House of Delegates of the American Medical Association is of the opinion that these principles should be considered by constituent and component medical societies together with all other facts pertinent to the local situations in all the controversies arising in the employment of medical faculty by state tax supported medical schools, and be fully considered in effecting action within the framework of this policy."

The Reference Committee on Medical Education and Hospitals agreed with that portion of the resolution regarding "unalterable opposition to socialized medicine" but recommended that the resolution be referred without approval or disapproval at this time, to the Council on Medical Service which currently is studying the various aspects of this subject. The House adopted the reference committee's recommendation.

Malpractice Insurance—Two resolutions and a Board of Trustees supplementary report, all dealing with the problems and difficulties in obtaining satisfactory professional liability insurance were considered together by the Reference Committee on Insurance and Medical Service.

The House of Delegates accepted the reference committee report which said:

"Inasmuch as the Board of Trustees has reported that there is in progress a study of the subject, we feel that we can well await the recommendations that the Board is planning to make at the next session. Due to the apparent emergency aspect of the problem, the Board of Trustees is urged to report to the membership as soon as possible through its component societies, on the progress of this urgent study."

Awards and Contributions—At the closing session of the House of Delegates, the A.M.A. received a citation for pioneering in helping to bring educational television to the American public. James Keller, chairman of the Miami Citizens Committee for Educational Television,

presented the award on behalf of the National Citizens Committee for Educational Television. Dr. Martin accepted the citation for the American Medical Association.

At the same session, the Utah State Medical Society presented a check for \$10,355 to the American Medical Education Foundation to aid in relieving the financial plight of the nation's medical schools. The contribution was received by Dr. Louis Bauer, President of the Foundation, who also announced that a check for \$1,000 had been contributed by the Southern Medical Association.

This summary on the proceedings of the House of Delegates at both the Miami and San Francisco meetings is not intended as a detailed report on all actions taken, but covers most of the important subjects taken up by the House.

Reference Committee recommendation—The report of the AMA Delegates was accepted as information with approval and commendation.

House of Delegates action—Recommended adoption of the AMA Delegates' Report as presented by the reference committee which was moved, seconded, and adopted.

Tenth District Councilor
Harry L. Cheves Sr.

The Tenth District had its two regular meetings, the summer one being well attended, and at the winter one the attendance was not as good as it should have been.

There has been some activity toward combining some of the small county societies, but this as in the past has met with very little success.

Tenth District Membership

Counties	Members Dec. 31, 1954		Members Dec. 31, 1953	
	MAG	AMA	MAG	AMA
Clarke-Madison-Oconee	43	36	41	34
Elbert	17	10	16	6
Franklin	4	4	6	4
Greene	3	3	1	1
Hart	5	—	6	4
McDuffie	5	4	6	6
Morgan	6	3	5	2
Richmond	195	153	184	143
Walton	10	9	9	8
Warren	2	2	2	2
Wilkes	15	10	16	10
Total	305	234	292	220

Reference Committee recommendation—The Report of the Tenth District Councilor, Harry L. Cheves, Sr., was accepted as information.

House of Delegates action—Recommended adoption of the Tenth District Councilor's Report as presented by the reference committee, which was moved, seconded, and adopted.

Medical Defense Committee
Marion C. Pruitt, Chairman

This has been an unusually active year for the Medical Defense Committee.

During the year there have been 31 suits and four complaints made.

Of the suits pending: One was filed in 1950, one 1951, three 1952, nine in 1953, 16 in 1954, one so far in 1955. Of this number four were closed and 27 are pending. Of the four complaints filed, two were closed and two are pending.

Attached (for Association Records only) is a more detailed report of individual cases as furnished by Mr.

John Dunaway, Attorney for the Medical Association of Georgia.

As in the past, most of these suits have followed misunderstandings, critical remarks (most often by someone in the profession without thinking), or some financial question.

The work of the committee with the attorney, Mr. Dunaway, and the members of the Association has been most cooperative. The greater part of the work was done by the attorney, which is as it should be, to prevent unnecessary publicity and unfairness in these cases.

Reference Committee recommendation—Report of the Medical Defense Committee, Marion C. Pruitt, Chairman, was accepted as information.

House of Delegates action—Recommended adoption of the Medical Defense Committee report as presented by the reference committee which was moved, seconded and adopted.

Woman's Auxiliary Advisory Committee
Enoch Callaway, Chairman

The Woman's Auxiliary Advisory Committee met with the Auxiliary early in the year and took part in planning the activities of the Auxiliary for the year.

The work of the Auxiliary continues to maintain its high standards, and their close cooperation with the committee and with the Medical Association of Georgia deserves the highest praise.

Since the Auxiliary report will cover their work done during the past year, we do not feel that any further report from the committee is necessary.

Reference Committee recommendation—The report of the Woman's Auxiliary Advisory Committee was accepted as information.

House of Delegates action—Recommended the adoption of the Report of the Woman's Auxiliary Advisory Committee as presented by the reference committee, which was moved, seconded, and adopted.

Rural Health Committee
George T. Nicholson, Chairman

At the Annual Session of the Medical Association of Georgia held in Macon in 1954, President Wright appointed me co-chairman of the Rural Health Committee with W. W. Turner, of Nashville. In July we learned with deep regret that, due to previous commitments, Dr. Turner would not be able to continue with the committee. At this time I would like to express to Dr. Turner my personal thanks and also those of the committee for his support and our regret that he could not continue.

From August 1 until the last of October we spent our time in orienting ourselves with the workings of the committee and with the reorganization of it. Dr. Wright has made the appointments and replacements on the committee as appear in your handbook.

The first meeting of the committee was held in Macon at the Dempsey Hotel. All but one member was present or sent an alternate to the meeting. This meeting was held November 14, 1954. It was the consensus of opinion that the duties of the committee as set forth in the Constitution and By-Laws were too narrow and should be changed. The entire rural health needs of the State were discussed and the following objectives were decided upon:

- (1) The need for more general practitioners and better distribution of physicians in the State.
- (2) The encouragement of better provision of facilities in rural areas to attract qualified physicians to them.
- (3) The need to educate physicians of the State on the Rural Health needs and then to educate the public

and to assist them in solving their problems.

(4) The need for accident prevention in the rural home and on the farm.

(5) The need for a standard program of immunization throughout the entire State.

(6) The need for more adequate care of mental illness and the particular problems of chronic alcoholism as a particular problem in rural areas.

(7) Members of the committee should visit the county societies in their congressional district and acquaint them with program of the Rural Health Committee.

(8) Fostering para-medical recruitment.

(9) That the Rural Health Committee of the Medical Association of Georgia should sponsor and help organize State-wide Rural Health Conferences annually.

Following through on this plan, we have screened the requests for physicians by having the community requesting a physician investigated by the committee-man from that district. If there was any controversy whatsoever the situation was referred to the Better Health Council of Georgia for a lay-opinion and an unbiased report.

The chairman of the committee attended the Rural Health Breakfast sponsored by the American Medical Association Council on Rural Health in Miami, Fla. as well as the National Rural Health Conference held in Milwaukee, Wis. At both meetings it was brought to our attention that the American Public is demanding a return to the true version of the "family physician" who is friend, confidante, physician and "father confessor". It is the feeling of the general public that there should be more general practitioners.

At the National Conference on Rural Health held in Milwaukee, Wis., there were three plans proposed which would encourage young physicians to enter general practice. It was shown that most medical students were exposed to specializations but were never given a view of the obligations and privileges of the general practitioners, more fondly called "family doctors". These three plans were:

(1) A compulsory preceptorship under a qualified general practitioner for a period of six weeks.

(2) A series of lectures to be given during the senior year to occupy six to eight weeks, one hour per week, to acquaint the student with the down-to-earth part of general practice and its rewards.

(3) Senior day. This is a program for a day or half day at which successful general practitioners and their wives rubs shoulders with the medical school seniors, their wives and sweethearts. The women talk over mutual problems while the men do the same.

The Committee on Rural Health of the Medical Association of Georgia therefore recommends that:

I. The Constitution and By-Laws of the Medical Association of Georgia be changed from its present status By-Laws, Section 1. (I) The Committee on Rural Health, to read:

(I) THE COMMITTEE ON RURAL HEALTH shall concern itself with improving the *health* of the more sparsely settled areas of the State as well as providing, to the best of their ability, adequate medical care for these areas. It shall be composed of one member from each of the Councilor Districts comprising the Association, in so far as possible they shall be physicians actively engaged in general practice. In addition

to these, other members shall be the Director of the State Department of Public Health and the President of the Better Health Council of Georgia who shall serve in an *ex-officio* capacity. It shall investigate and make recommendations as to locating and staffing health centers and shall cooperate with the Council on Rural Health of the American Medical Association. The Committee shall designate a member to represent the Medical Association of Georgia at National Conferences on Rural Health.

II. The general program of the Committee on Rural Health of the Medical Association of Georgia as heretofore outlined be endorsed by the House of Delegates of the Association.

Addendum

I realize that it is rather unusual to submit a supplemental report, but two matters of importance have come about since the annual report in the *Handbook* was submitted as our report for the Committee on Rural Health.

While our committee is very new, it has been quite active. We have approached the problem of physician placement from a more realistic viewpoint. A brochure has been prepared ready for printing by Charles T. Brown, Guyton, committee member from the First District, which acquaints the community desiring a physician with what requirements should be met and incorporates in it a score sheet so that the community may rate itself on the possibilities of obtaining a physician. The brochure is entitled "So Your Town Wants a Doctor," and we of the committee respectfully recommend and request that this brochure be printed and distributed to communities requesting the MAG to aid them in obtaining a physician.

Secondly, a "Senior Day" program has been arranged to be held in Augusta June 1 for the Medical College of Georgia and June 2 in Atlanta for the Emory University School of Medicine. These programs will acquaint the senior medical students with the advantages of general practice in rural Georgia.

Reference Committee recommendation—The Report of the Rural Health Committee was accepted as information. The committee is commended for its hard work and industrious effort. The idea of a brochure is commended; however, the committee is incompetent to judge material not in hand at this time.

House of Delegates action—Recommended adoption of the Rural Health Committee Report and Addendum as presented by the reference committee, which was moved, seconded, and adopted.

A.M.E.F. Committee

John L. Chandler, Jr., Chairman

During the past year 39 individual physicians throughout the state contributed \$1,503.00. The Eighth District Medical Society contributed an additional \$400.00, thanks largely, I am sure, to the efforts of a member of this committee, Sage Harper of Douglas. The Woman's Auxiliary contributed \$603.00 making a total of \$2,506.00 as Georgia's contribution toward keeping our medical schools from federal subsidization. This represents an increase of approximately \$500.00 given over the year 1953.

For this sum in 1954, Emory University received \$23,682.50 and the Medical College of Georgia \$24,534.00. A total of \$48,036.50 in "free money" grants. In other words for every dollar given by Georgia physicians to the A.M.E.F. in 1954, the medical schools in the state got back approximately \$20.00. A real good investment!

As you know, it was my privilege to attend the meeting of all the State Chairmen of the Committee for A.M.E.F. in Chicago January 1954 and again in January 1955. At the first meeting I heard the plans of various chairmen for raising money during the coming year, at the last meeting the results of those plans. With few exceptions they met with indifferent support. Five or six states, mostly those with the larger population, contributed well over half of all monies contributed to A.M.E.F. Utah, with 535 dues paying physicians on the roll of its medical association, gave \$11,090.00. This was due to an assessment of \$20.00 per member. This plan worked.

A.M.E.F. must be supported or else one of two things will happen. Either the medical schools will close or the Federal or State Government will step in and take them over.

It is my sincere belief that the Georgia physicians would rather be assessed \$5.00 or \$10.00 a year knowing that 100 per cent of this will go toward supporting our medical colleges than to face the possibility of additional federal taxation. There are over 2100 dues paying members of the Medical Association of Georgia. An assessment of only \$5.00 per member would amount to

Reference Committee recommendation—Report of the AMEF Committee accepted with disapproval of the part of the report suggesting that each member be assessed. It is recommended that donations be left on a voluntary basis.

House of Delegates Action—Recommended the adoption of the AMEF Committee Report, with the exception of the "assessment proviso" as noted by the reference committee and this report be approved as presented by the reference committee which was moved, seconded, and adopted.

Crawford W. Long Memorial Committee

Lester Rumble, Jr., Chairman

This year has seen much progress toward our goal of a suitable Memorial Museum to Crawford W. Long in Jefferson, Georgia. It will also serve as a tribute to the late Frank K. Boland, since it was through his efforts that this action was started. The events of the year can best be outlined:

1. A grant of \$25,000.00 was received late in 1954 from ex-governor Herman Talmadge, to be utilized by the State Historical Commission to begin construction and revision of the building which occupies the site of Dr. Long's famous discovery.
2. Architect's plans and specifications have been completed, and bids for construction have been let. It is anticipated that construction will be in progress when this report is read.
3. Due to the need for certain accessory facilities, such as rest room space and inside stairway, a small piece of adjoining property has been purchased and the deed placed in the hands of the State authorities.
4. A proposed change in the Constitution and By-Laws of the Medical Association of Georgia has met with favorable action, and this committee will become a standing committee as of this year.
5. The original \$1,000.00 given by the Association two years ago for the maintenance of the Museum upon completion is still intact. It is anticipated that further requests for funds will be unnecessary until the end of this year, since completion of the building will take that long.
6. The Auxiliary of the Medical Association of Georgia and the citizens of Jefferson have pledged aid in the maintenance of this project.

Reference Committee recommendation—Report of the Crawford W. Long Memorial Committee was accepted as information.

House of Delegates action—Recommended adoption of the Crawford W. Long Memorial Committee report as presented by the reference committee, which was moved, seconded, and adopted.

Chronic Illness Committee

L. Minor Blackford, Chairman

Today it would be trite to say that the number of old people, many disabled with the infirmities of age, is constantly increasing; or that the number of younger people more or less disabled with chronic illness is also constantly increasing. It would be trite to add that the increased lifespan of those not economically independent is very largely the result of efforts of the medical profession. It is not trite, however, to insist that the success of the physicians' efforts in prolonging existence lays upon us the moral obligation of taking the lead in laying plans for the care of those who are no longer able to take care of themselves.

The Georgia Heart Association has provided an example of what doctors can do when they put their minds to it. Last year more than 23,000 visits were made by patients to the Association's various clinics. Your committee would like particularly to call attention to the Giddings Memorial Clinic opened July 2, 1954, at St. Joseph's Infirmary. This clinic is equipped to do any type of diagnostic procedures, and to carry out any type of operation on the heart yet devised. It has already served patients from 20 north Georgia counties.

The Elks' beautiful new Aidmore, now on the grounds of Emory University, is doing a swell job caring for children ill with rheumatic fever or convalescing from other long-term illnesses, but, to be utilized to its full capacity, it needs more financial support from the state. In passing, your committee is glad to note that the reception of Negro children at Aidmore caused no cataclysm. If there were a dozen more such institutions, equally good, strategically located around the state, with adequate funds for running expenses, except for mental disorders the rising generation of Georgians would be well fixed.

Gracewood is becoming more crowded every year. The state hospital in Milledgeville bears the unenviable distinction of being the biggest in the world. More psychiatric health centers around the state should serve to decrease the number of admissions to Milledgeville, and it has been argued that five times as many psychiatrists working in the hospital would so greatly increase the number of patients ready for discharge in a few months that the tax-payers' bill would be appreciably diminished. The laws on sterilization might also be more strictly enforced.

Last August Congress passed the Administration's Medical Facilities Act. The purpose of this act, which may be considered an extension of the Hospital Survey and Construction (Hill-Burton) Act, is to assist in the erection of chronic disease hospitals, nursing homes, diagnostic clinics and rehabilitation centers. The Division of Hospital Services of our Department of Health is already engaged in a state-wide survey to determine our needs and to perfect plans for meeting them.

Many nursing homes in Georgia, like Topsy, just grew. In the past two years, following inspection by state authorities, the managers of some of them have formed an organization which has voluntarily adopted a set of standards. The number of those who can meet these standards is constantly being increased. It must

be reiterated that inmates of a nursing home should be under the supervisory care of a physician, preferably the one of their choice. These patients are best cared for in the neighborhood of their old home, and they should have access to a general hospital for a short stay when the need arises. It is desirable moreover that each of them should spend a few days in a hospital for complete diagnostic studies and the correction of such conditions as can be corrected before he enters a nursing home. The hospital should cooperate with the nursing homes in its vicinity by retaining nurses and other ancillary personnel, such as laboratory technicians, physical and occupational therapists, to work with these patients in the nursing home or, better, in their own homes, and they must of course work under the direction of a physician.

In the opinion of your committee, one of the great needs of Georgia at this time is the establishment of schools associated with one or the other medical college to train physical and occupational therapists. It is believed that the only way we are going to get enough of them who are willing to stay in Georgia is to train our own young people.

Your committee for several years has been talking about the need for additional facilities for physical rehabilitation in Georgia. It is happy to hear reports that the Eugene Talmadge Memorial Hospital in Augusta and the new Grady Memorial Hospital in Atlanta are planning such facilities. Your committee is also delighted to read that the Atlanta Chamber of Commerce has as its number one health project this year the establishment of a regional rehabilitation center in Atlanta. Under the provisions of the Medical Facilities Act, this project seems entirely feasible.

Reference Committee recommendation—The report of the Chronic Illness Committee was accepted as information.

House of Delegates action—Recommended adoption of the Chronic Illness Committee report as presented by the reference committee, which was moved, seconded, and adopted.

Executive Secretary

Mr. Milton D. Krueger and Mr. John F. Kiser

In reviewing the past year, it is with pride that the staff of the Headquarters Office can report consistent progress in administering the affairs of the Association. No one member can realize the increased duties carried by the staff, nor is it easy to visualize the new business-like procedures instituted. The Association's Secretary has referred to many of the new activities in detail that have been initiated by the staff of the Headquarters Office and the Association committee reports also give concrete evidence of the expanded service rendered by office staff.

As executive secretary of the Association, I wish to express my appreciation to those Association officers, committee chairmen and members who have devoted so many hours of their time to the affairs of the organization. Especially noteworthy was the cooperation of MAG committee chairmen and county medical society secretaries.

I also wish to express my gratitude to the headquarters office staff. Mrs. Mulligan, secretary; Miss Porcher, MAG Journal managing editor; Miss Franklin, bookkeeper and recorder; and Mr. John F. Kiser, assistant executive secretary, have made possible all improvements and progress of the past year. Without their efforts and unlimited cooperation, the work load carried by this office could not have been achieved.

Recommendation:

That the Medical Association of Georgia Constitution and By-Laws carry a specific section defining (1) authority, (2) composition, and (3) duties of the headquarters office so that this office may function on all occasions in a matter suitable to all members of the Association under the direction of the Council of the Association. This section would then provide a basic organization and responsibility for the headquarters office. The section should also clarify the responsibilities of the executive secretary and his relationship to the Association Council and the Association Secretary.

Reference Committee recommendation—The Report of the Executive Secretary was accepted for information. No action was taken.

House of Delegates action—Recommended that the reference committee recommendation on the Report of the Executive Secretary be approved as presented by the reference committee, which was moved, seconded, and adopted.

Better Health Council

Mrs. Bruce Schaefer, President

The annual meeting of the Better Health Council of Georgia was held in June 1954, at which time new officers were elected: Mrs. Bruce Schaefer, Toccoa, president; Dr. Tully Blalock, president-elect; Mrs. Edgar Dunstan, secretary; Robert F. Whitaker, treasurer.

At the annual meeting, the By-Laws were amended to provide for a Board of Directors not to exceed 35 members. While the Board of Directors is not complete, the council has been fortunate in securing many outstanding leaders in the state who are interested in and willing to help plan and execute its statewide program.

Since June, the office has been without an executive secretary. Mrs. William Reid, former executive secretary, resigned to accept the position as administrator of the Newton County Hospital, Covington. The details of the office have been handled by Mrs. Charles Skinner, office secretary, who has also made many of the outside contacts.

Accomplishments During 1954

1) Sponsored three regional health conferences which included 82 counties with approximately 750 people attending, of which 75 per cent represented local lay groups. The programs were planned by local leaders in cooperation with a representative from the council.

Such subjects were discussed as: School Child Health including Proper Sanitation and Cleanliness; Dental Hygiene; Safety, in the home, in the school and on the school bus; Cooperation of Parents, Doctor, Dentist, School Nurse, in eye tests, dental care, chest x-rays and other phases of everyday living which contribute to building healthy school children.

Other subjects were: Hospital and Health Insurance; Environmental Sanitation; Nutrition as Related to the Soil; Mental Health; Dental Health and Fluoridation of Water; Problems of the Aging Group; Health Councils in Local Communities; Health Services, which are offered to local citizens through the voluntary and official health organizations.

2) In addition to the three regional conferences, the council co-sponsored a one-day meeting with a county medical society, the Industrial Health Committee of the Medical Association of Georgia and the Georgia Association of Industrial Nurses. The theme was "Team Work in Family and Community Health."

3) Distributed the health pamphlets of member agencies at all conferences and meetings. This material gave

hundreds of people the opportunity to learn more about the health services which are available to them through the voluntary health agencies.

An attractive exhibit of health pamphlets is kept in the office of the council and is available to the public.

4) The regional conferences were followed-up with a questionnaire to each person who registered. The information gathered was passed on to the State Department of Public Health and to other avenues for further follow-up.

5) Assisted in organizing and reactivating 12 community health councils. (There are many requests for assistance from local communities which have not been answered due to lack of staff and finances.)

6) Issued three editions of *Newsletter*. The last one was devoted to health councils.

7) The office is rendering a public health information service through the daily telephone inquiries about health services which are available through the city and county health departments and the voluntary health agencies.

8) Five organizations joined the council during the year, making a total of 53 participating and contributing members: Pepperell Manufacturing Company, Georgia Association for the Help of Retarded Children, National Multiple Sclerosis Society, Atlanta Chapter, National Association for the Prevention of Blindness and Muscular Dystrophy Association, Fulton-DeKalb Chapters.

9) The Legislative Committee cooperated with the State Department of Public Health, the Medical Association of Georgia and the voluntary health agencies in presenting appropriate health bills to the General Assembly.

Future Program

1) A continuous cycle of regional health conferences.

2) A more intensive program of personal contact with lay groups in the state and with local health councils.

3) Placing health pamphlets of member agencies in school libraries. (Pamphlets have already been placed in county libraries.)

4) Presenting television forums as often as gratis time is available.

5) Cooperating with the Rural Health Committee of The Medical Association of Georgia on Physician Placements.

6) Cooperating with the Governor's Committee and the Board of Regents in placing doctors in small communities who have received scholarships for their medical education through the State Medical Education Board of Georgia.

7) Supporting appropriate health bills in the General Assembly.

8) Increasing the mailing list of *Newsletter*.

Addendum

Mr. Chairman, members of the House of Delegates and ladies: I bring greetings from the Better Health Council of Georgia to the Medical Association of Georgia and its Auxiliary in convention, here assembled.

The council's report is published on page 108 of the *Delegates Handbook*—I invite your attention to this report in its entirety.

May I briefly bring the report up-to-date.

1. The council has actively assisted in the arrange-

ments of attendance of those interested in the health aspect for three civil defense workshops with the State Department of Defense.

2. A committee from the council will meet next week with the Secretary of the State Medical Education Board of Georgia, as requested by them to present recommendations for placing and follow-up of medical graduates under this program.

3. Tuesday of this week, the council will make another report to the Rural Health Committee of the Medical Association of Georgia at their request—on a study of seven communities in relation to the communities' requests for doctor placement.

4. In March, I attended the National Health forum in New York serving as a discussant on the "Health Career Horizons Project" of the National Health Council sponsored by Equitable Life Assurance Society of the U. S. Dr. Howard Rusk commented on the excellence of the Health Career Guide Book pointing up 156 careers in the health field. The Better Health Council has plans underway to utilize this guidebook in the junior high and high schools of Georgia.

In closing, may I make an observation? Meeting with and studying the programs and problems of many of our 53 health, member-agencies observing the 12 new community health councils in Georgia—I am more firmly convinced that the community health council is the answer to solving the community's own health needs and problems and further coordinating and planning for efficiency in utilization of existing facilities.

May I go a step further? After attending the National Health Council with representatives from government, public health, 50 public, professional, and volunteer health agencies, I am more keenly cognizant of the urgent need for getting to the grass-roots level to Mr. and Mrs. John Q. Public with the proper information and guidance for solving their own health problems and properly evaluating their own health needs.

How better can this be done than by following AMA's suggestion of organizing community health councils?

From past experience this can best be accomplished by a state health council composed of all state elements able and willing to contribute to better health planning.

The Better Health Council of Georgia is guided in principle and activities by the leadership provided by the Medical Association of Georgia.

The council appreciates the confidence and the support of Medical Association of Georgia, and believes that a state and community health council are the best media for public understanding of organized medicine. I thank you.

Reference Committee recommendation—The Report of the Better Health Council was accepted, and we commend the council for its sincere and industrious work throughout the year 1954-55. The Association is deeply indebted to these members who represent the physicians of Georgia.

House of Delegates action—Recommended adoption of the Better Health Council Report and Addendum as presented by the reference committee, which was moved, seconded, and adopted.

Resolution on Medical Care Commission

Introduced by

C. M. Mulherin, Augusta

WHEREAS, it has become increasingly apparent in recent years that there is an acute need for provisions for hospitalization, medical care, and treatment for

indigent sick persons of Georgia who are either partially or completely financially unable to pay the cost of hospital care and treatment; and

WHEREAS, at the present time no such provisions exist in many hospitals in the state and only a few counties without a hospital provide any funds for paying for care of their indigent sick persons who are hospitalized in another county; and,

WHEREAS, this problem has been recognized as serious by various committees of the Medical Association of Georgia and by numerous other organizations including the Georgia Hospital Association, the Joint Commission for the Improvement of Patient Care, the Georgia State Nursing Association, the two medical schools, the Better Health Council of Georgia, the Georgia Pediatric Society, the Georgia Academy of General Practice, the Georgia State Obstetrical and Gynecological Society, and the State Health Department; and

WHEREAS, steps have been taken in recent years to plan for care of the indigent sick on a state level in other southern states including Florida, Tennessee, North and South Carolina, Alabama, and Maryland.

NOW THEREFORE BE IT RESOLVED BY THE HOUSE OF DELEGATES OF THE MEDICAL ASSOCIATION OF GEORGIA, that a resolution be introduced at the next session of the Georgia General Assembly recommending that a Medical Care Commission be created to study the problem of hospitalization, medical care and treatment for indigent sick persons of Georgia, to determine the need for such care and to determine responsibilities of the state and counties for such care.

BE IT FURTHER RESOLVED THAT this Medical Care Commission investigate, study and make a survey as to the following matters:

1. The extent of state, county, and municipal aid to general hospitals under present state and local laws.
2. The general background of the financial problems now facing voluntary, public, and private hospitals.
3. The responsibility, if any, which the State of Georgia, the counties or cities or other public authorities might have for meeting hospital deficits caused by care for the indigent.
4. A plan or plans to provide hospitalization and medical care and treatment for indigent sick persons financially unable to provide the hospital and medical care, the methods and procedures by which such hospitalization and attention can be provided, and the possible cost of such plan or plans, and whether funds may be provided for said purpose, and if so, by whom;
5. Any other related matters reflecting upon the feasibility or possibility of providing hospitalization and medical care for indigent sick persons in Georgia.

Reference Committee recommendation—The committee approves the Resolution on Medical Care Commission and strongly endorses the action outlined in the resolution.

House of Delegates action—Recommended the adoption of the Resolution on Medical Care Commission as presented by the reference committee, which was moved, seconded, and adopted.

Resolution on Rheumatic Fever

Introduced by

Joseph C. Masee, Fulton County

WHEREAS, present medical knowledge, properly applied, makes possible the control of streptococcal infections, and

WHEREAS, the control of streptococcal infections offers the possibility of greatly reducing the incidence of initial and recurrent attacks of rheumatic fever, and

WHEREAS, the Georgia Heart Association is inaugurating a professional and public information program to encourage full use of presently accepted prophylactic measures against streptococcal infections,

NOW THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia lend its full endorsement to this effort to "Stop Rheumatic Fever," and commend it to medical societies and physicians throughout the state for their active support.

Reference Committee recommendation—Resolution on the Georgia Heart Association's program "Stop Rheumatic Fever" was approved by this committee.

House of Delegates action—Recommended adoption of the Resolution on Rheumatic Fever as presented by the reference committee, which was moved, seconded, and adopted.

REPORT OF REFERENCE COMMITTEE NO. 5

W. L. Pomeroy, Chairman

(The following reports as presented to this committee are printed in full with the reference committee's recommendation and the action pursuant to it by the House of Delegates.) Members of Reference Committee No. 5 present were as follows: W. L. Pomeroy, Chairman; John Turner, Vice-Chairman; W. W. Bryan, Charles T. Cowart, Gerald B. Hogsette, Lynn M. Huie, D. W. Schmidt, and Stephen D. Smith.

Secretary

David Henry Poer

As I come to the end of the first year of my second term as your secretary-treasurer, I pause to express my appreciation for the strong vote of confidence given me last Spring at the time of our Annual Session and to point out to all members, including the opposition, the fact that we have striven to correct our faults and to carry on the work of this office in a manner that would meet with the approval of all members. We are again happy to report progress which I believe to be in keeping with the growth of the organization and within its financial capabilities.

Membership

In 1954 the Association had 2,210 active members which is the largest number in its history. Added to this are 225 associate members and 186 life members making a grand total of 2,621. It is interesting to note the increase in membership in the face of the increase in dues. This seems to indicate that with more money this office can give more services which is what our members want as long as it is within reason.

The various methods of classifying members has presented serious bookkeeping difficulties which have caused us to recommend changes in the Constitution and By-Laws to make ours similar to that of the AMA. There is strong need for this to be done.

It is recommended that all county societies classify their members in the same manner as the headquarters office beginning January 1, 1956.

Committee Activities

Approximately 50 per cent of our committees are working hard and have accomplished a great deal. This shows improvement, and it is probable that many of the

other committees will get into action during 1955; this office stands ready to give any necessary assistance. It is interesting to note that the accomplishments of a committee almost always parallel the enthusiasm of a chairman who can organize and develop a program for his committee without waiting for it to be provided for him. Specifically, some of the committee activities will be discussed here as follows:

Legislation. You will hear much about the successful activities of this committee under Chairman Coker who was ably assisted by Senator Ayers and Representative Mashburn, but mostly perhaps, by our own assistant executive secretary, Mr. John Kiser. The legislature felt the impact of our influence which we hope we can continue to use for the best interests of the health of the people of Georgia. Despite the personal friendship of Governor Griffin for many doctors, we still seem to be unable to exert any worthwhile influence upon the appointments that he is making on state medical boards and in other health matters. It has been suggested that a liaison committee be appointed to see if this situation could be corrected.

Constitution and By-Laws. My own experience with this committee goes back to 1949 when the first efforts were made to bring this instrument into a more modern and working form corresponding with the present day activities of the Association. It is, therefore, with a great deal of personal pleasure that I report that the finished product seems almost in sight. Changes have been made to make it simpler and easier to follow and to correct contradictions that could have been embarrassing. Attempts have been made to separate the administrative duties from the legislative powers and to eliminate overlapping functions. Committee structure has been strengthened so that frequent changes in personnel can be avoided, and the duties of each committee have been set down more accurately.

Insurance. This committee is organized better than ever before and is working hard to solve the many insurance problems that confront us. Perhaps our greatest progress has been in attempting to find methods to prevent the steady increase in rates for professional liability insurance, and a special joint conference with representatives from the medical societies of adjoining states has been held for that purpose. The future of the Georgia Plan must be decided by the members, and, in order to bring this about, it is probable that one man from this office will be assigned to that work for several months or until the final solution has been found.

Annual Session. After several years of trial and error the method of handling the program for the Annual Session seems to be working smoothly; the Committee on Scientific Work deserves much praise for this accomplishment. As it now works, this committee sets up the general structure for the program and the special sections then select their own guest speakers as well as local speakers from within the state. In this way the specialty groups hear the speakers discuss the topics that they themselves choose and this method naturally pleases almost everyone. Also, the general practitioners have been taken into consideration and have been given one day during which time they invite the guest speakers to talk on subjects of interest to them. Commercial exhibits are now handled in a business-like fashion in a way that pleases the exhibitors and has attracted an increasing number each year. At this meeting we have

exactly twice as many exhibits as were shown when the Association met here four years ago. Much more interest is now shown in the scientific exhibits and actually we have been short of space during the past two years.

Council. This organization is now assuming its rightful responsibilities for the operation of the Association and all councilors have participated in this work in a very serious manner. In fact, about 75 per cent of the vice-councilors have also attended the regular meetings of Council indicating the increased interest in the activities of the Association. The Executive Committee of Council has also been active, holding its meetings regularly and using the telephone for conferences to prevent unnecessary travel. This has proven extremely beneficial to me in keeping the members of this committee informed of the activities in this office and helping to make necessary decisions.

Headquarters Office. The long planned expansion of our offices has finally taken place; we now have one additional large office which can be used for conferences, and the inside office has been enlarged to take care of two desks. With the exception of a separate room for the Woman's Auxiliary, we now have adequate space to house the work of the organization for many years to come. All members are urged to visit the headquarters whenever it is possible.

Other noteworthy activities in the headquarters office include the *Newsletter* which is now sent to 250 key members of the Association every two weeks. When the Legislature was in session, it was issued each week, and this plan will be followed in the future whenever urgent affairs take place. We find this a most satisfactory method of keeping county societies and officers informed about important activities because of the time lag in publishing the *Journal*. It has been suggested that our mailing list be increased to include other members of the Association, and I will be glad to follow your direction in this matter. The expense of mailing it to all members would be an item to consider.

In the *Journal* there now appears on a yellow sheet the report from the Executive Secretary, which contains pertinent information about matters of interest to the members. This information includes reports from the AMA offices in Washington and Chicago concerning medical matters of political interest.

The travel plan of our executive secretaries has finally gotten under way, and Mr. Kiser and Mr. Krueger have visited the officers of most of the county societies in the state during the year. The plan now is to have Mr. Kiser in the field at least half the time, and he will make every attempt to visit the county society meetings whenever possible. You are requested to let us know if special problems exist in which we could be of assistance to you.

County Societies. More progress took place in 1954 in promoting the amalgamation of smaller county societies with nearby larger ones than during any other year. This has occurred in two places, and it is probable that several other combinations will be effected within this coming year. This promotes efficiency in operation and is worked out to the benefit of all societies concerned. Minimum standards for county societies have been inaugurated by Council, and this is a noteworthy achievement. This will do much to promote efficient operation of our county units acting as a guide for that purpose.

House of Delegates. The organization of this body has been improved and now works more efficiently and smoothly. This was especially noteworthy at the time of our first special meeting in Macon, which in itself indicated the seriousness with which the members are taking such matters for proper decision. Reference committees have been enlarged and receive their work well enough in advance to make their decisions more deliberate and valuable.

Better Health Council. The work of this organization has been studied by Council in view of the fact that more money is appropriated for its support than for any MAG committee. Actually there is overlapping of its functions with our own Rural Health Committee, and perhaps others as well. A decision must be made soon as to the advisability of continuing our financial support or transferring these funds to our own committees. A recommendation from the House of Delegates is requested.

Conclusions and Recommendations

To continue the efficient operation of this office and to render more services better to our members, more furniture and equipment will be required in the headquarters office. This will include a desk, typewriter, table, sound equipment (dictaphone), a bookkeeping file and chairs. It is also probable that an additional typist will be required especially if one of the men stays in the field most of the time. Increased travel will also require an increase in appropriations for this purpose since it is necessary to provide transportation plus a per diem to compensate for being away from home.

Salaries require constant study and adjustments in line with present day living costs. This includes that of your secretary-treasurer who is now required to direct the activities of a five man office on an allotment that has not been changed since 1928. The approval of the House of Delegates is needed to continue the work now being carried on by your headquarters staff.

Few other specific recommendations have been made herein since most of these have been made directly by changes in the Constitution and By-Laws.

Reference Committee recommendation—Membership: The committee recommends that the secretary's report concerning membership be approved;

Committee Activities: The committee recommends that a liaison (legislative) committee be appointed, and approves this portion of the secretary's report;

Committee Activities: The committee strongly endorses the designation of one day as 'General Practitioners Day' and the devotion of that day's program to papers of particular interest to general practitioners;

Committee Activities: The committee recommended that a newsletter mailing be continued and that special section chairmen and others who request that the newsletter be sent to them be included on the mailing list within the discrimination of the secretary, the budget permitting.

Committee Activities: The committee endorses the plan of travel as proposed, within the limits of the budget;

Committee Activities: The committee is in favor of the amalgamation of smaller societies for the formation of more efficient units;

Committee Activities: The committee recommends that, in addition to the chairman, all members of the reference committee be informed in advance of the meeting, of matters to be considered by their committee;

Committee Activities: Concerning the Better Health Council, it was noted that this report had been referred to Reference Committee No. 4 for action.

Conclusions and Recommendations: It is the opinion of this committee that these items should be referred to the Council for consideration and consultation with the budget committee for their consideration. It is also the recommendation of the reference

committee that the remarks in the conclusions and recommendations of the secretary, specifically concerning the constant study of salaries in the headquarters office be referred to Council for favorable consideration. The chairman of the committee then moved that the reference committee recommendations be accepted with the alterations and comments suggested by Reference Committee No. 5.

House of Delegates action—Recommended adoption of the Secretary's Report with the alterations recommended by the reference committee which was moved, seconded, and adopted.

Treasurer David Henry Poer

Attached herewith is the report of the audit of the financial operations of the Association for the year ending December 31, 1954. The complete statement will be published in the JOURNAL in accord with action of the House of Delegates in Macon last year.

Comparison with the auditors' report for 1953 reveals a substantial increase in the general operating funds of the Association. This no doubt is due to two factors, namely, (a) increase in number of dues-paying members and (b) increase in dues. The excess of assets over liabilities rose from \$8,869.91 on December 31, 1953 to \$20,417.70 on December 31, 1954.

The fixed funds of the Association show a moderate increment due to interest and dividend payments. Together these exceed \$72,000.00 with \$6,257.42 earmarked for the Calhoun Lectureship and \$65,922.00 put aside in the Benevolent and Building Fund. There have been no withdrawals from either of these funds, and pension allotments have been paid out of the general funds.

The question has been raised as to the advisability of investing a part (up to 50 per cent) of these latter funds in blue chip or preferred stocks which would increase their income considerably. The Calhoun funds are invested in this manner. Council now has this matter under advisement and would appreciate an expression of opinion from the House of Delegates. An alternate suggestion has been made that funds not to exceed \$25,000.00 be made available for loans to medical students to be repaid with a moderate rate of interest, beginning five years after entering private practice. Even though several funds are available for this purpose, there are many worthy and interested prospective medical students who need financial assistance. From the standpoint of good relations, this action would indicate to the public at large the serious interest of physicians in assisting more qualified men to enter the profession. This would offset the criticism of the profession that has been publicized on many occasions.

Even though it is not the policy of the Association to publish the JOURNAL for profit-making purpose, it is pleasant to note that in 1954 it operated within its budget. The same can be said concerning the management of the Annual Session. The figures for the latter are subject to considerable variation due to the differences both in number and in desirability of exhibit facilities.

Mention has been made of salaries in the Secretary's Report, but it can be repeated here that these should follow increases both in responsibility and in living costs. It is planned to keep these at as fair and economical a level as is commensurate with the performance of duties in an enthusiastic fashion. No drastic salary changes are planned at the present time.

Statement of Assets and Liabilities—By Funds

	DECEMBER 31, 1953				DECEMBER 31, 1954			
	Benevolent and Abner W. Calhoun		Building and Lectureship Funds		Benevolent and Abner W. Calhoun		Building and Lectureship Funds	
ASSETS	General Fund	Combined	General Fund	Combined	General Fund	Combined	General Fund	Combined
Cash on deposit	\$ 8,752.61				\$ 31,578.41			
Securities owned:								
At cost	—	63,320.00	5,800.85	69,120.85	—	50,000.00	6,101.85	56,101.85
At redemption values	—	—	—	15,922.00	—	15,922.00	—	15,922.00
Accounts receivable	4,095.20	—	—	4,095.20	—	—	—	3,898.28
Travel deposit	3,722.55	—	—	3,722.55	—	—	—	425.00
Office furn. & equip.—Note A	1,032.93	—	—	1,032.93	—	—	—	\$ 3,927.94
Less allowance for depreciation	2,689.62	—	—	2,689.62	—	—	—	1,414.97
Prepaid annual meeting expense	303.08	—	—	303.08	—	—	—	\$ 2,512.97
TOTAL ASSETS	\$15,820.51	\$63,320.00	\$5,986.99	\$85,127.50	\$38,564.18	\$65,922.00	\$6,257.42	\$110,743.60
LIABILITIES								
Accounts payable for expenses	\$ 131.75	—	—	\$ 131.75	\$ 70.23	—	—	\$ 70.23
Withholding and payroll taxes	668.85	—	—	668.85	—	—	—	—
Membership dues held in suspense	—	—	—	—	—	—	—	126.25
Deferred income:								
Membership dues collected	—	—	—	—	—	—	—	—
Subscriptions to The Journal	—	—	—	—	—	—	—	—
Exhibitors fees—annual meeting	—	—	—	—	—	—	—	—
Collected	—	—	—	—	—	—	—	—
Due from exhibitors	6,150.00	—	—	6,150.00	—	—	—	3,975.00
TOTAL LIABILITIES	\$6950.60	—	—	\$ 6,950.60	\$18,146.48	\$17,950.00	—	\$2,625.00
Excess of Assets Over Liabilities	\$ 8,869.91	\$63,320.00	\$5,986.99	\$78,176.90	\$20,417.70	\$65,922.00	\$6,257.42	\$92,597.12

Note A—Office furniture and equipment is stated at cost and does not include items purchased prior to April 1, 1949.

Statement of Income and Expense—By Funds

The Medical Association of Georgia
Year Ended December 31, 1954

	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
INCOME				
Membership dues—				
Note A:				
Year 1954	\$43,390.00	\$ —	\$ —	\$43,390.00
Prior years	170.00	—	—	170.00
Net income from The Journal—as shown by schedule	3,712.36	—	—	3,712.36
Interest on U. S. Savings bonds:				
Received—Note B	1,250.00	—	—	1,250.00
Increase in redemption value	—	494.00	—	494.00
Dividends, stocks owned	—	—	283.33	283.33
TOTAL INCOME	\$48,522.36	\$494.00	\$283.33	\$49,299.69
EXPENSE				
Salaries:				
Secretary and treasurer	\$ 3,000.00	\$ —	\$ —	\$ 3,000.00
Executive secretary	5,700.00	—	—	5,700.00
Asst. executive secy.	2,400.00	—	—	2,400.00
Clerical	7,025.00	—	—	7,025.00
	\$18,125.00	\$ —	\$ —	\$18,125.00
Trustees' fees	—	—	12.90	12.90
Expenses of 1954 annual meeting, less fees from exhibitors of \$7,350.00	76.26	—	—	76.26
Administrative and other expenses—as shown by schedule	19,296.43	—	—	19,296.43
TOTAL EXPENSE	\$37,497.69	\$ —	\$ 12.90	\$37,510.59
	\$11,024.67	\$494.00	\$270.43	\$11,789.10
OTHER INCOME				
Received from A.M.A. for services, postage, etc.	523.12	—	—	523.12
NET INCOME	\$11,547.79	\$494.00	\$270.43	\$12,312.22

Note A—\$5.00 from annual dues of each member has been allocated to subscriptions to The Journal.

Note B—On May 10, 1953, The Council authorized interest received on U. S. Savings bonds held in the Benevolent and Building Funds to be recorded in the General Fund.

Reference Committee recommendation—(1.) That Council be directed to study the advisability of investing at least a part of the reserve funds of the Association in high grade stocks and bonds. This committee approves this recommendation, with the notation that such study is already within the range of the normal functions of Council.

(2.) The establishment of a Student Loan Fund by setting aside \$10,000 from the reserve fund. The reference committee recommends that this recommendation be deleted from the Treasurer's Report.

(3.) That the itemized financial statement attached, be published in the Journal, along with the proceedings of the House of Delegates. The reference committee approves this recommendation.

The chairman of this committee moves that this report be accepted with the alterations and comments suggested by Reference Committee No. 5.

House of Delegates Action—Recommended adoption of the Treasurer's Report with the alterations and comments noted by Reference Committee No. 5 which was moved, seconded, and adopted.

Honorary Advisory Board

Enoch Callaway, Chairman

The Honorary Advisory Board held two meetings during the past year and considered and made recommendations to Council on several problems presented to them.

The attendance of the members of the Honorary Advisory Board has been very poor, and I, as chairman, do not feel that the committee as a whole has functioned in a very satisfactory manner.

It is my opinion that the members of the Council are much more familiar with the problems which arise than are the members of the Honorary Advisory Board. I would recommend that meetings of this board be called only when their advice is desired by Council.

Reference Committee recommendation—This committee approves the Report of the Honorary Advisory Board with the recommendation that meetings of the Honorary Advisory Board be called only when their advice is requested by Council. The chairman of Reference Committee No. 5 moves that this report be accepted with alterations and comments as suggested by Reference Committee No. 5.

House of Delegates action—Recommended adoption of the Honorary Advisory Board Report, with the alterations and comments suggested by Reference Committee No. 5, which was moved, seconded, and adopted.

Professional Conduct Committee

Enoch Callaway, Chairman

The Professional Conduct Committee has had several problems referred to it during the past year.

All of the problems have been satisfactorily handled except in one case. Final handling of this case has been postponed on advice of the American Medical Association.

A full report of the proceedings and activities of the Professional Conduct Committee has been made to Council and is on record at the Medical Association of Georgia offices. It is not thought advisable to publish a full report of these proceedings in the *Journal*.

Reference Committee recommendation—Reference Committee No. 5 approves this report.

House of Delegates action—Recommended the adoption of the Professional Conduct Committee Report as approved by Reference Committee No. 5, which was moved, seconded, and adopted.

Awards Committee

Hoke Wammock, Chairman

The Awards Committee has two important functions to perform. One of its functions is that of promoting and planning the scientific exhibit section at the annual session and the awarding of appropriate certificates for the best scientific exhibit.

The other function is making nominations for General Practitioner of the Year and for Certificates of Appreciation.

It is recommended that each district present nominees for the Hardman Award and the General Practitioner of the Year with their respective biographies to the Committee on Awards on or before January 1st of each year. The committee will then select the most suitable candidate for the Hardman and the General Practitioner Awards. The nominees for the Hardman Award and the General Practitioner Award will be presented at the annual meeting of the House of Delegates.

We wish to emphasize the fact that the scientific exhibit section is one of the most important functions of the annual session. We wish to express our appreciation to those presenting scientific exhibits at the annual session in 1954. There were 30 exhibits. These

represented a most healthy contribution to the progress of medicine in Georgia. We again wish to encourage physicians in Georgia to participate in this phase of the Annual Session.

Reference Committee recommendation—It is recommended by Reference Committee No. 5 that sentence 2 in paragraph 3 reading, "the committee will then select the most suitable candidate for the Hardman and the General Practitioner Awards" be changed to read as follows, "the committee will then select the most suitable candidates for the Hardman and General Practitioner Awards and present their names to the House of Delegates for election." It is further recommended that a short biographical sketch of these candidates be submitted and published in the delegates handbook, stating the basis for each candidate's consideration. The chairman of Reference Committee No. 5 moves that this report be accepted with the alterations and comments suggested by Reference Committee No. 5.

House of Delegates action—Recommended the adoption of the Awards Committee Report with alterations and comments as suggested by Reference Committee No. 5, which was moved, seconded, and adopted.

Insurance Board

David R. Thomas, Jr., Chairman

The Insurance Board has met a number of times since the meeting of the Medical Association of Georgia in Macon in 1954. In addition, there have been a number of meetings of subcommittees of the board, and the years work was consummated at a meeting held in Atlanta, April 2 and 3, 1955. In addition to the valuable work of the members of the board, the chairman is indebted to the services of Mr. Dunaway, Mr. Krueger, and Mr. Kiser, as well as the secretary of the Association and our president. The work that has been accomplished could not have been done without the invaluable assistance and cooperation of many men in the insurance companies.

At the time of our last meeting in Atlanta, representatives of other southeastern states were present representing the states of Virginia, North Carolina, Alabama, and Oklahoma, and we had personal communications from South Carolina. Mr. Dick Graham, Executive Secretary of the Oklahoma State Medical Association, was present at this meeting, at our request.

Throughout the year, John Elliott, Savannah, has handled the unlisted procedures for insurance claims as well as those unusual claims, making it possible for just and equitable settlements to be made by the insurance companies. This is a necessary and integral part of the functions of the Insurance Board.

Group Life Insurance: After much work, the group life insurance of the Medical Association was underwritten by the Provident Life and Accident Insurance Company and became effective October 15, 1954. The board feels that this group life insurance makes it possible for those members of the Medical Association of Georgia who would not ordinarily be insurable, to have this additional protection for their estates. This plan is working satisfactorily, and all new members of the Association will have the opportunity of participating in the plan regardless of their insurability.

Professional Liability Insurance: As many doctors in Georgia are only too acutely aware, there has been a sharp rise in the cost of malpractice insurance over the past several years. There seems to be no reason to hope that this rise will not continue in the future. For this reason, a committee was assigned to study this problem and to make suggestions as to how the problem might

be handled better in our state. Following considerable investigation and study by the committee, the following points seem to be of importance:

1. It is extremely difficult to get the actual cost figures of insurance companies upon which they determined their premium rate.

2. The claims experiences of the various insurance companies are also very difficult to obtain.

3. There seems to be too great a tendency on the part of insurance companies to settle all claims out of court, making such matters easy bait for those who would be interested in making malpractice claims.

4. In general, insurance companies are not too interested in going into the cause of the rise of premiums, and attempting to treat the disease on the basis of cause. Insurance companies seem only interested in raising premiums when such can be justified before the insurance commission.

5. The above would seem to make only one solution apparent, and that is the establishment of a group insurance policy for malpractice in the State of Georgia. This solution has already been carried out in several other states. These plans have been studied by our malpractice committee.

It is not the purpose of the committee to attempt to get cheap insurance. The objective is to get good insurance at the best possible rate. It is the feeling of the committee, and of those to whom we have gone for advice, that better insurance can be in force at a lower price on the basis of a group policy. Under this plan the doctors themselves will have more to do with the administration of the insurance.

The brief resume outlined above was presented to the Council of the Medical Association of Georgia at one of their previous meetings, and since that time efforts have been made by the Insurance Board to find a company which would write insurance using the general principles as outlined in the report to Council. About 200 companies, in groups or individually, were contacted. No company which is a member of the National Board of Surety and Casualty Underwriters will participate in such a program as we have in mind. They will not agree for the medical profession to participate in their information in any way. By that, it is meant that they refuse to submit their records for the scrutiny of the medical profession. After considerable discussion and elimination, the Insurance Board voted unanimously to adopt a plan which was presented by the Saint Paul-Mercury Indemnity Company. This plan is essentially similar to the scheme outlined above. This same company writes a group malpractice insurance in Oklahoma. In the course of the committee's investigation, the executive secretary of the Oklahoma Medical Association came to Atlanta by invitation. He was very outspoken and very liberal in his praise of the program, and of the insurance company.

Recommendation: It is the recommendation of the Insurance Board that the House of Delegates approve the Saint Paul-Mercury as the agent to write malpractice insurance in the State of Georgia.

It is further recommended by the Insurance Board that the House of Delegates empower said committee to make such decisions, and to take such actions as will be necessary to establish a malpractice insurance program for the doctors of Georgia.

The Georgia Plan: The Georgia Plan has been very unsuccessful in the past due to many inequities that we have finally been able to correct. With the able assistance and advice of many capable insurance men from throughout the country, and the untiring efforts of a subcommittee, the fee schedules have been reviewed and revised so that the surgical fees have been brought into line as to a just and reasonable fee for the low income group.

Optional benefits of both the anesthesiologist's fee and the fee for medical visits in *hospital only* were approved by both the Insurance Board and the Health Insurance Council. It was agreed by both the Insurance Board and the Health Insurance Council that benefits to cover radiological fees not be included in the Georgia Plan at this time; further study will be necessary.

Congenital anomalies will be covered in group policies under the Georgia Plan, and individual contracts offer the same coverage on the optional basis by obtaining coverage on an unborn child during or before the ninth month of gestation.

It has been determined that persons eligible for the full service benefit coverage be revised as follows: Single persons whose income does not exceed \$2,400.00 a year, or married persons whose *aggregate family income* does not exceed \$3,600.00 a year, or a married person whose aggregate family income does not exceed \$3,600.00 a year with an additional \$200.00 allowance per child up to four children, for each child under 19 years of age, a total not to exceed \$4,400.00.

Income limits for eligibility for payment under the Georgia Plan of the full service feature revision were discussed and approved by both the Health Insurance Council and the Insurance Board. It was brought out that the Association must write new participating physicians and old participating physicians to renew them under the provisions of the revised plan. It was approved by the Insurance Board and the Health Insurance Council that the three following circumstances negate the application of the service feature.

1. If the subscriber and/or dependent, while a bed patient in a hospital, voluntarily selects accommodations more expensive than semi-private accommodations, the service feature no longer applies regardless of the patient's income.

2. If the subscriber and/or dependent has two or more insurance policies, each of which pay surgical, obstetrical or medical benefits, the service feature is not applicable regardless of the patient's income.

3. In case of injury in which the subscriber and/or dependent might receive additional compensation for his injuries either in a court settlement or in an out-of-court settlement, the service feature is no longer applicable regardless of the patient's income.

The surgical fee schedule has been revised and the medical and anesthesia optional schedules are included; the Blue Book of the Georgia Plan is to be rewritten in detail.

The Insurance Board is of the unanimous opinion that since the Medical Association of Georgia has inaugurated a Georgia Plan, that it is necessary that all physicians in the State of Georgia be encouraged and requested to support this plan. Simply stated, it is a plan whereby those people of a very limited income group will be able to carry the insurance necessary to

provide medical care, as it could not be done without insurance and the support of physicians.

The Insurance Board has recommended that the fee for answering life insurance queries as to the health of a patient be set at \$3.00. This, in no way, forces the insurance companies to comply, but merely establishes a minimum fee, if the insurance companies are interested in getting the information that they seek from the physicians of Georgia.

The board feels that much has been accomplished during the past year and that with the support and co-operation of all members of the Medical Association of Georgia, that invaluable services can be rendered both to the people of the State of Georgia as well as those of us in the medical profession.

A keen responsibility is realized in our necessity for promoting increased knowledge by both the profession and laymen of Georgia in developing an insurance program that will meet our need. Such a program can be killed by a lack of knowledge of limitations of insurance as well as unwillingness of the profession and the laymen alike to cooperate in the insurance program.

It has to be realized that *cheap insurance is cheap* and very little is gotten from it, except misunderstandings and unsatisfactory coverage. Each of us in purchasing insurance or interpreting the provisions of an insurance policy, must realize that there are limitations, and they have to be understood.

Much has been done and even more remains to be accomplished.

Reference Committee recommendation—(1.) The reference committee recommends that the information on group life insurance be accepted as information.

(2.) The reference committee recommends that the professional liability insurance data be approved with the following alterations: approved the Saint Paul-Mercury Indemnity Company as the agent to write the group professional liability insurance for the Medical Association of Georgia. The reference committee further recommends as follows: "It is further recommended by the Insurance Board, that the House of Delegates empower the board to make such decisions and to take such action as will be necessary to establish malpractice group insurance programs for the Medical Association of Georgia."

Concerning the Georgia Plan, the committee recommends as follows, "the Georgia Plan, because of the great care and work which the Insurance Board, in whom we have full confidence, have given to their study, it is recommended that their report and their recommendations be approved with alterations suggested by this reference committee, and that the importance of calling the patient's and doctor's attention to exceptions No. 1, No. 2 and No. 3 in the report be emphasized." It is recommended that paragraph 2 be changed as follows: "If the subscriber and/or dependent has two or more insurance policies, each of which pays surgical, obstetrical, medical, or anesthesiological benefits, the service feature is not applicable regardless of the patient's income." The Report of the Insurance Board as a whole, was accepted with the recommendation that the Insurance Board be commended for its work. The chairman of this committee moved that this report be accepted with alterations and comments suggested by Reference Committee No. 5.

House of Delegates action—Recommended adoption of the Report of the Insurance Board and the comments and suggestions of the reference committee along with the alterations as presented by the reference committee.

After some discussion concerning both the professional liability insurance plan and the Georgia Plan, C. H. Richardson, of Macon, suggested that the name "malpractice insurance" be changed to professional liability insurance. This suggestion was approved.

The reference committee report was then seconded and adopted as a whole.

Speaker Simonton then commended Dr. Thomas and his whole committee for their preparation of this report and for the excellent work done by the members of the board over the past year.

REPORT OF REFERENCE COMMITTEE NO. 6

B. L. Shackelford, Chairman

(The following reports as presented to this committee are printed in full with reference committee recommendation and the action pursuant to it by the House of Delegates.) Members of Reference Committee No. 6 present at the meeting were as follows: B. L. Shackelford, Chairman; Enoch Callaway, Fred Simonton, Glenn Seymour, J. J. Pilcher, and J. W. Chambers, *Ex-officio*.

Report of Constitution and By-Laws Committee J. W. Chambers, Chairman

This committee has met several times during the year and the attached report represents the work done by the committee at its various meetings. In addition to the members of the committee as appointed, the president, Dr. Peter B. Wright, and the president-elect, Dr. H. Dawson Allen, gave generously of their time and attended the various meetings.

All recommendations received by the committee have been given thoughtful consideration and have been filed in the working notes of the committee.

The committee would like to express its appreciation to Mr. John Kiser and Mr. Milton Krueger for their fine cooperation in providing secretarial and editing assistance throughout the year.

The committee has attempted to completely re-write the Constitution and By-Laws, wherever possible, to make it agree with that of the American Medical Association as adapted to the needs of our own Association, always attempting to strengthen the organizational structure of the Medical Association of Georgia and to allow it to function more smoothly and efficiently.

We respectfully submit the following report for your consideration:

Now Reads:

CONSTITUTION ARTICLE I.

Name of the Association

The name of this organization is The Medical Association of Georgia.

Will Read:

CONSTITUTION ARTICLE I.

Name of the Association

The name of this organization is The Medical Association of Georgia. It is an association of its component county medical societies.

Now Reads:

ARTICLE II.

Purposes of the Association

The purposes of the Association shall be to advance the science of medicine; to promote the interests and uphold the honor of the profession of medicine; to acquire, utilize and disseminate information relative to all diseases and degenerative processes affecting mankind to the end that the people of Georgia may have the most adequate medical care possible; to promote public health, and to foster cordial relations between the members of the medical profession and the general public.

Will Read:

ARTICLE II.

Purposes of the Association

The purposes of the Association are to promote the science and art of medicine and the betterment of public health.

Now Reads:

ARTICLE III.

Component Societies

Component societies are those county medical societies which hold charters from the Association or which may hereafter be organized and chartered by the House of Delegates of the Association.

Will Read:

ARTICLE III.

Component Societies

Component societies are those county medical societies which hold charters from the Association or which may hereafter be organized and chartered by the House of Delegates of the Association to form the Medical Association of Georgia.

Now Reads:

ARTICLE IV.

Composition of the Association

Sec. 1. The Association is composed of members and delegates.

Sec. 2. Members. The members of the Association are the members of the component county medical societies.

Sec. 3. Delegates. Delegates are those members elected in accordance with this Constitution and By-Laws to represent their component county medical societies in the House of Delegates of the Association.

Will Read:

ARTICLE IV.

Membership

SEC. 1. MEMBERS. The members of the Association are the members of the component county medical societies. The Association is composed of Active, Service, Associate and Honorary members as provided for in the By-Laws. Other types of membership may be provided for in the By-Laws.

SEC. 2. TENURE OF MEMBERSHIP. A member shall retain his membership as long as he complies with the provisions of the Constitution and By-Laws and with the Principles of Medical Ethics of the American Medical Association.

Now Reads:

ARTICLE V.

House of Delegates

Sec. 1. Powers. The legislative body of the Association is the House of Delegates and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.

Sec. 2. Composition. The House of Delegates is composed of (1) delegates elected by the component county medical societies, (2) the officers and past presidents of the Association and (3) the delegates to the American Medical Association.

Will Read:

ARTICLE V.

House of Delegates

SEC. 1. COMPOSITION. The House of Delegates is composed of delegates selected by the component county medical societies as provided in the By-Laws. The general officers, the Past Presidents and Past Councilors of the Association, the Treasurer, Editor of the JOURNAL, Delegates to the AMA, the Executive Secretary and Chairmen of Standing Committees shall be *ex-officio* members of the House of Delegates without the right to vote.

SEC. 2. DUTIES. The House of Delegates is the legislative body of the Association, and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.

Now Reads:

ARTICLE VI.

Council

Sec. 1. The Council shall be the Board of Trustees and the Board of Censors of the Association. It shall carry out the mandates and policies as determined by the House of Delegates. The Council shall have full authority and power of the House of Delegates between sessions of that body. The Council shall have charge of all the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

Sec. 2. The Council shall consist of the President, the President-Elect, the Secretary-Treasurer and one Councilor from each Congressional District in the State of Georgia.

Will Read:

ARTICLE VI.

Council

SEC. 1. COMPOSITION. The Council is composed of the Presi-

dent, the President-Elect, the Immediate Past-President, two Vice-Presidents, the Secretary, the Speaker of the House of Delegates, and 10 Councilors as provided for in the By-Laws. The Treasurer, Editor of the JOURNAL, Executive Secretary and Delegates to the AMA shall be *ex-officio* members of Council without the right to vote. Vice-Councilors shall be *ex-officio* members except in the absence of their respective Councilors as provided for in the By-Laws. The Vice Speaker shall be an *ex-officio* member except in the absence of the Speaker as provided in the By-Laws.

SEC. 2. DUTIES. The Council is the Board of Trustees and the Board of Censors of the Association. It carries out the mandates and policies as determined by the House of Delegates. The Council has full authority and power of the House of Delegates between sessions of that body. The Council has charge of all the property and financial affairs of the Association and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

Now Reads:

ARTICLE VII.

Sessions and Meetings

Sec. 1. Annual Session. The Association shall hold an annual session during which there shall be general meetings open to all registered members, delegates and guests.

Sec. 2. Time and Place. The time and place for holding each annual session shall be fixed by the Council.

Sec. 3. Special Meetings. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Council, twenty delegates or upon written petition of one-fourth of the members of the Association.

Will Read:

ARTICLE VII.

Meetings

SEC. 1. ANNUAL SESSION. The Association shall hold an Annual Session at a time and place fixed by Council.

SEC. 2. HOUSE OF DELEGATES. The House of Delegates shall meet during the Annual Session and in interim sessions as may be determined by Council.

SEC. 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of Council, 20 delegates or upon written petition of one-fourth of the members of the Association.

Now Reads:

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts, which shall be coextensive with the Congressional Districts in Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies.

Will Read:

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts and for the organization of all component county societies in the districts into Councilor District Medical Societies.

Now Reads:

ARTICLE IX.

Officers

Sec. 1. Officers. The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor, and a Vice-Councilor, from each of the Councilor District Societies as provided in the By-Laws. All elections shall be held as prescribed in the By-Laws.

Sec. 2. Election and Eligibility. The officers of the Association shall be elected by the members during the annual session. No person shall be eligible to an elective office who has not been a member of the Association for the preceding three years.

Sec. 3. Terms of Officers. The President-Elect shall be elected annually. He shall become President on his installation at the close of the next annual session. If the President-Elect be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session. Other officers shall be elected for terms of one year each, except the Secretary-Treasurer and the Councilors who shall serve for three years. One-third of the Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

ARTICLE IX.**Officers**

SEC. 1. DESIGNATIONS. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, the Immediate Past President, the Secretary, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, 10 Councilors and 10 Vice-Councilors as provided for in the By-Laws.

SEC. 2. ELECTION AND ELIGIBILITY. The officers of the Association shall be elected during the Annual Session as provided for in the By-Laws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.

SEC. 3. TERM OF OFFICE OF PRESIDENT-ELECT. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. If the President-Elect shall be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session.

SEC. 4. TERMS OF OTHER OFFICERS. Other officers shall be elected for terms of one year each except the Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates and the Councilors who shall serve for three years. One third of the Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

SEC. 5. SUCCESSOR TO THE PRESIDENT. If the President dies, resigns, or is removed from office, the First Vice-President shall immediately become President and shall serve for the remainder of the unexpired term. If the First Vice-President is unable to serve, then the Second Vice-President shall fill the office.

Now Reads:

ARTICLE X.**Funds and Expenses**

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component county medical society. The amount of the assessment shall be set annually by the House of Delegates upon the recommendation of the Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates.

The Council shall submit an annual budget to the House of Delegates. The Council shall manage the finances of the Association and shall supervise all funds, investments and expenditures of the Association. All resolutions providing for appropriations, recommended by Council, shall be included in the annual budget, subject to final approval by the House of Delegates.

Will Read:

ARTICLE X.**Funds and Expenditures**

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component county medical society. The amount of the assessment shall be set by the House of Delegates upon recommendation of Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by Council. The Council shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

Now Reads:

ARTICLE. XIII.**Amendments**

The House of Delegates may amend this Constitution by a two-thirds vote of the Delegates present at any annual session, provided that such amendment shall have been presented to the House of Delegates at the previous annual session and that it shall have been published during the year in The Journal of the Association, or sent officially to each component county society at least two months before the annual session at which final action is to be taken.

Will Read:

ARTICLE. XIII.**Amendments**

The House of Delegates may amend this Constitution at any session by a two-thirds vote of the Delegates present, provided that the proposed amendment shall have been introduced at the preceding session and provided that the proposed amendment shall have been published during the year in the JOURNAL.

Now Reads:

BY-LAWS**CHAPTER 1.****Membership**

Sec. 1. Any physician holding the degree of Doctor of Medi-

cine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been adjudged guilty of moral turpitude or other serious crime, may be eligible for membership in a component society of the Association.

Will Read:

BY-LAWS**CHAPTER 1.****Membership**

SEC. 1. A physician holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been judged guilty of moral turpitude or other serious crime, may be eligible for membership after being certified by the secretary of a component society as being a member in good standing of said component county society.

Now Reads:

Sec. 3. Membership in the Association shall be classified as active, associate, honorary, life and scientific.

Sec. 4. Active Members. All members shall be active, including the right to vote and hold office, unless otherwise classified by action of the component county society.

Sec. 5. Associate Members. Any physician who is not engaged in the regular practice of medicine for any one of the following reasons, namely: (1) during organized periods of hospital training and graduate education, (2) during periods of service in the Armed Forces, (3) after retirement or (4) for whom the payment of dues would constitute a hardship, may be classified by the component county society as an associate member. Associate Members shall be entitled to all the rights and privileges of the Association except that they shall not pay dues or receive The Journal without subscription thereto.

Sec. 6. Honorary Members. Eminent physicians and other persons who have distinguished themselves in the science of medicine, or for contributions to human welfare, may be elected to Honorary Membership in the Association by the House of Delegates upon nomination by any component county society and approval of the Committee on Professional Conduct of the Medical Association of Georgia. Such Honorary Members may be issued an appropriate certificate of membership without payment of dues.

Sec. 7. Life Member. A Life Membership may be granted by the House of Delegates, upon the recommendation of the component county society, to any physician who has had not less than forty years of active membership in the Association or has passed his seventieth birthday. He shall not be subject to payment of dues.

Sec. 8. Scientific Members. There shall be created a new division of membership to be known as Scientific Membership. The privileges of membership under this classification shall entitle the holder thereof to all phases of the Association's activities pertaining to the study of scientific medicine, and shall include the right to attend all scientific meetings, postgraduate study courses, and scientific sessions of component organizations. Scientific members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to Medical Defense or to receive The Journal except by regular subscription.

Sec. 9. A physician who is under sentence of expulsion from a component county society, or whose name has been dropped from its roll of members, shall not be entitled to any of the rights, privileges or benefits of the Association, nor shall he be permitted to take part in any of its proceedings.

Sec. 10. The cause of the failure of a practicing physician to affiliate himself with an available component county society, at any time, shall be ascertained before election to membership.

Sec. 11. Eligible physician members of the State and Federal medical services and full time members of approved medical facilities not engaged in private practice of medicine shall pay half the annual dues of the Association provided similar action has been taken by the component county society.

Will Read:

SEC. 3. Membership in the Association shall be classified as Active, Service, Associate and Honorary.

SEC. 4. ACTIVE MEMBERS. Physicians who are members in a component county medical society and are eligible to vote and hold office in the society shall be Active members, unless otherwise classified by action of the component county society. These members shall have full privileges of Association membership

including the right to hold office and vote, the privilege of Medical Defense and receipt of the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, and these members shall pay full dues to the Association annually. New members entering practice after July 1st may pay one half the annual dues.

Active members may be excused from the payment of Association dues for one of the following reasons: financial hardship or illness, post-graduate training, defined as that period during which a member participates in an organized training course within a hospital, and being retired from active practice. A member in good standing who is over 70 years of age may also be excused from the payment of Association dues upon his application to the Association through his component county society; this exemption to begin the year following the member's 70th birthday. Active members excused from the payment of Association dues shall have the right to vote and hold office but shall not have the privilege of Medical Defense and shall not receive any publication of the Association except by personal subscription.

SEC. 5. SERVICE MEMBERS. Physicians eligible for Service membership are all full-time commissioned Medical Officers in the Regular or Reserve U. S. Army, Navy, Air Force and Indian Service, and those physicians who have been retired from the Services by Federal law and who do not engage in active practice. These members shall not have the right to hold office and vote, and shall not receive any publication of the MAG except by personal subscription, nor shall they receive the privilege of Medical Defense. These members shall not be required to pay annual dues for the period beginning January 1 or July 1 following the date of the member's entrance into service.

SEC. 6. ASSOCIATE MEMBERS. Associate membership may be granted to physicians who are engaged in State, County and Federal medical services and full-time salaried members of approved medical faculties not engaged in the private practice of medicine provided similar action has been taken by the component county society. Associate membership may also be granted to those members of component county societies who are not eligible for Active membership in the component county societies. Associate members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to the privilege of Medical Defense or to receive any publication of the Association except by personal subscription.

SEC. 7. HONORARY MEMBERS. Physicians who have risen to prominence in the profession may be elected to Honorary membership by the House of Delegates. Nominations for Honorary membership may be submitted to the House of Delegates by component county societies or Council. These members shall enjoy all the privileges of the Association but shall not vote or hold office nor shall they receive the privilege of Medical Defense or any publication of the Association except by personal subscription.

SEC. 8. TENURE. When the Secretary is officially informed that a member is not in good standing in his component society, he shall remove the name of that member from the Membership roll.

SEC. 9. TRANSFER. Should a member remove his practice to another jurisdiction he shall apply for a continuance of his membership through the component society in the jurisdiction to which he has moved his practice.

Now Reads:

(CHAPTER II.)

Sec. 2. The program for the general meetings shall be prepared by the Committee on Scientific Work and approved by the executive committee of the Council at least 60 days before the Annual Session of the Association and published in the issue of The Journal preceding the Annual Session.

Will Read:

SEC. 2. The program for the general meetings shall be prepared by the Committee on Scientific Work and approved by the Executive Committee of Council at least 60 days before the Annual Session of the Association and published in an issue of the JOURNAL preceding the Annual Session.

Now Reads:

Sec. 3. All papers read before the meetings shall become the property of the Association, and shall be deposited with the Secretary-Treasurer immediately after being read. Failure to comply with this and other rules set forth by the Committee on Scientific Work regarding papers, discussions and exhibits shall automatically bar scheduled participation in the scientific sessions in the future from this member for a period of not less than five years unless he presents an acceptable excuse.

Will Read:

SEC. 3. All papers read before meetings shall be deposited with

the Secretary or the presiding officer and shall become the property of the Association. Without an acceptable excuse, failure to comply with this and other rules as regard the Annual Session as set forth by the Committee on Scientific Work, shall automatically prohibit a member from participating in scheduled scientific sessions for a period of not less than five years.

Now Reads:

Sec. 4. Upon invitation of the President any physician may register at a general meeting of the Association as a guest upon presentation of adequate evidence of membership in good standing in a component unit of the American Medical Association.

Distinguished lay persons and physicians may be invited as special guests of the Association by the President or by action of the Council. Privileges of the floor may be extended to guests at the discretion of the presiding officer.

Will Read:

SEC. 4. The general meetings shall be open to all registered members. Distinguished lay persons and guest physicians may be invited as special guests of the Association by the President or by action of Council.

SEC. 5. LOCAL ARRANGEMENTS COMMITTEE. At the close of each Annual Session, the component society which will act as host at the next Annual Session, shall elect Local Arrangements Committees which shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of Council.

Now Reads:

CHAPTER III.

House of Delegates

Sec. 1. The House of Delegates shall meet on the first and last day of the annual session at a time fixed by the Council and at such other times as may be necessary for the transaction of the business of the Association.

Will Read:

CHAPTER III.

House of Delegates

SEC. 1. MEETINGS. The House of Delegates shall meet during the Annual Session at a time and place fixed by Council. The House of Delegates may also meet in interim sessions and at such other times as may be necessary for the transactions of the business of the Association as may be determined by Council.

Now Reads:

Sec. 2. Each component county society shall elect one delegate and a corresponding alternate for each twenty-five members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. It shall be the duty of the President to have the representation of each component county society checked by the Committee on Credentials at the time of the annual session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy.

Will Read:

SEC. 2. Each component county society shall elect one delegate and a corresponding alternate, each of whom who has been a member in good standing for the prior three years, for each 25 members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. Delegates to the House of Delegates shall serve for a term of three years; one-third of the members of the House of Delegates to be elected annually provided that the component county societies which are entitled to three or more delegates shall elect at their first election, one-third of their delegation for a term of one year, one-third of their delegation for a term of two years and one-third of their delegation for a term of three years and thereafter elect such delegates whose terms of office expire therewith. Those component county societies which are entitled to less than three delegates shall elect their delegate or delegates for staggered terms in rotation as may be determined by Council until one-third of the House of Delegates is being elected annually.

Now Reads:

Sec. 5. The Secretary-Treasurer of the Association shall be the Secretary of the House of Delegates or, in his absence, by a delegate appointed by the President. The Executive Secretary may serve in this capacity.

Will Read:

SEC. 5. The Secretary of the Association shall be the Secretary of the House of Delegates or, in his absence, a Delegate appointed by the Speaker of the House of Delegates shall serve as Secretary of the House of Delegates. The Executive Secretary may serve in this capacity.

Now Reads:

Sec. 6. *The following shall be the general Order of Business at all meetings of the House of Delegates: 1. Call to order by the President; 2. Roll Call; 3. Election of Speaker and Speaker pro tem; 4. Reading and adoption of minutes; 5. Reports of officers; 6. Reports of Committees; 7. Unfinished business; 8. New business.*

Will Read:

Sec. 6. The following shall be the general Order of Business at all meetings of the House of Delegates: 1. Call to Order by the Speaker; 2. Roll Call; 3. Reading and Adoption of Minutes; 4. Reports of Officers; 5. Reports of Committees; 6. Unfinished Business; 7. New Business. At any meeting, the House by majority vote may change the Order of Business. New Business may be introduced at the final meeting of the House of Delegates only when such business is of an emergency nature or introduced by unanimous consent.

Now Reads:

Sec. 7. *For the purpose of expediting proceedings the President shall appoint from the members of the House of Delegates the Reference Committees and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in the debate, but shall not have the right to vote.*

Will Read:

Sec. 7. For the purpose of expediting proceedings, the Speaker of the House of Delegates shall appoint from the members of the House of Delegates the Reference Committees and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in the debate, but shall not have the right to vote.

Now Reads:

(CHAPTER IV.)

Sec. 2. *The Council shall be composed of the President, the President-Elect, Vice-Presidents, Secretary-Treasurer, and one Councilor or Vice-Councilor from each Councilor district. Each Councilor and Vice-Councilor shall be nominated by each district society at the time of its annual meeting. In the event of a vacancy in the office of a Councilor and Vice-Councilor, the vacancy may be filled temporarily by appointment by the President from members of that district society.*

Will Read:

CHAPTER IV.

Council

SEC. 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice-Presidents, the Secretary, Speaker of the House of Delegates, or the Vice-Speaker of the House of Delegates and one Councilor or Vice-Councilor from each Councilor District. Vice-Councilors shall be *ex-officio* members of Council except in the absence of their respective Councilors when they shall serve as Councilors. The Vice-Speaker shall be an *ex-officio* member of Council except in absence of the Speaker, then he shall act in the Speaker's stead. The Treasurer, Editor of the JOURNAL, Executive Secretary and Delegates to the AMA shall be *ex-officio* members of Council without the right to vote.

Now Reads:

Sec. 4. *The Chairman of the Council shall be elected annually at the organization meeting and shall serve one year, or until his successor is elected. He shall preside over its meetings and appoint all necessary committees. A Vice-Chairman shall be elected from among its members. The Secretary-Treasurer of the Association shall be the Secretary of the Council.*

Will Read:

SEC. 2. CHAIRMAN AND SECRETARY. A Chairman and Vice-Chairman of Council shall be elected annually at the organizational meeting and shall serve for one year, or until their successors are elected. The Chairman or Vice-Chairman shall preside over meetings of Council and appoint all necessary committees. The Secretary of the Association shall serve as Secretary of Council.

Now Reads:

Sec. 3. *The Council shall set up an Executive Committee composed of the President, Secretary-Treasurer, Chairman of the Council and two other members of the Council. The President shall be the chairman of the Executive Committee. It shall meet not less often than bi-monthly to review the affairs of the Association. The Committee shall make recommendations to the*

Council and shall carry out such items of business as are referred to it by the Council.

Will Read:

SEC. 3. EXECUTIVE COMMITTEE. The Council shall organize an Executive Committee at the first meeting. The Executive Committee shall be composed of the President, the President-Elect, the Immediate Past President, the Secretary, the Chairman of Council, who shall serve as presiding officer, and the Chairman of the Council Committee on Auditing and Appropriations. It shall meet at intervals of not more than four months apart between the meetings of Council. The Committee shall make such recommendations to the Council and shall carry out such items of business as are referred to it by Council. The Executive Committee shall appoint all committee chairmen and committees of the Association not otherwise provided for, subject to confirmation by Council, and shall serve as Publications Committee of the JOURNAL. The Executive Committee shall appoint a Treasurer of the Association annually as provided for in these By-Laws.

Now Reads:

Sec. 1. *The Council shall meet on the last day of the annual session of the Association to organize and at intervals of not more than four months apart until the next annual session. Special meetings of the Council may be held on the call of the President or upon request of three members of the Council.*

Will Read:

SEC. 4. MEETINGS. The Council shall meet at the close of the Annual Session to organize and at intervals of not more than four months apart until the next Annual Session. Special meetings of Council may be held on the call of the President or upon request of three members of Council. Regular meetings of Council will be held on the call of the Chairman.

Now Reads:

Sec. 5. *The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws.*

Sec. 12. *The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the annual session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it for the good of the Association without restriction.*

Sec. 14. *The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between annual sessions of the Association. The appointee shall serve until his successor has been elected and installed.*

Sec. 17. *The Council shall provide such headquarters for the Association as may be required to conduct its affairs.*

Will Read:

SEC. 5. GENERAL DUTIES. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall provide such headquarters for the Association as may be required to conduct its affairs. The Council shall by appointment fill any vacancy in office not otherwise provided for, which may occur during the interval between Annual Sessions of the Association. The appointee shall serve until his successor has been elected and installed.

The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the Annual Session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it without restriction for the good of the Association.

Now Reads:

Sec. 10. *The Council shall provide for and superintend the issuance of all necessary publications of the Association, including proceedings, transactions and memoirs.*

Sec. 15. *The Council may appoint an Assistant Secretary-Treasurer or an Executive Secretary—either or both and fix their terms of employment.*

Sec. 16. *The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association subject to approval of the House of Delegates.*

Will Read:

SEC. 6. SPECIFIC DUTIES. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association and may appoint an Assistant

Secretary and/or Executive Secretary—either or both, and fix their terms of employment. The Council shall control and direct all Association publications.

Now Reads:

Sec. 6. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to the Association. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

Will Read:

SEC. 7. BOARD OF CENSORS. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to the Association. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association or upon the request of the party concerned. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

Now Reads:

Sec. 7. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in, the betterment of the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

Will Read:

SEC. 8. COUNCILOR AND VICE-COUNCILOR DUTIES. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in the betterment of, the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the Annual Session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

Now Reads:

Sec. 11. The Chairman of the Council shall appoint from among its members, a committee of three members to be known as the Committee on Auditing and Appropriations, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each annual session. This proposed budget shall be prepared by the Committee on Auditing and Appropriations for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval after which it becomes effective. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Sec. 13. The Council shall appoint, at least six months before the annual session, a committee, consisting of three or more of its members, to be known as the Committee on Arrangements for the annual session. This committee shall appoint a general chairman of a local committee on arrangements, who shall be a member of the component society in which the annual session is to be held. This local Chairman shall appoint, from the members of his county society, the personnel of the local committee

on arrangements. The local committee on arrangements shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements for the annual session. All expenditures made by that committee in connection with the annual session must be authorized in advance by the Committee on Auditing and Appropriations of the Council. Immediately after the annual session the Committee on Arrangements of the Council shall forward to the Secretary-Treasurer any accumulated balance. Auditing and Appropriations.

Sec. 18. The Council shall have control of all technical exhibits at the annual sessions.

Will Read:

SEC. 9. COMMITTEE ON AUDITING AND APPROPRIATIONS. The Chairman of the Council shall appoint from among its members, a committee of three members to be known as the Committee on Auditing and Appropriations, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each Annual Session. This proposed budget shall be prepared by the Committee on Auditing and Appropriations for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committees in connection with the Annual Session must be authorized in advance by the Committee on Auditing and Appropriations. Council shall have control of all commercial exhibits at the Annual Sessions and any deficit created on account of the Annual Session shall be met by Council on recommendation of the Committee on Auditing and Appropriations.

Now Reads:

CHAPTER V.

Election of Officers

Sec. 1. The President-Elect, Vice-Presidents, Secretary-Treasurer, Councilors and Vice-Councilors shall be elected by ballot by the members of the Association. Nominations for these officers except Councilors and Vice-Councilors shall be made orally as the last order of business at the first meeting on the first day of the scientific session. No nominating or seconding speech shall exceed two minutes. The President shall appoint a Committee of not less than three Tellers immediately after the close of nominations who shall have charge of the election.

Sec. 2. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations for Councilor and Vice-Councilor from such district shall be made from the floor. One third of the Councilors and Vice-Councilors shall be elected annually.

Will Read:

CHAPTER V.

Election of Officers

SEC. 1 ELECTION. The President-Elect, two Vice-Presidents, Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, Councilors and Vice-Councilors shall be elected by ballot by members of the Association during the Annual Session. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. Other officers shall be elected for terms of one year each except the Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, Councilors and Vice-Councilors who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually.

SEC. 2. NOMINATIONS. Nominations for these officers except Councilors and Vice-Councilors shall be made orally from the floor as the last order of business at the first General Session of the Annual Session and no nominating or seconding speech shall exceed two minutes. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the Annual Session. If no nomination is presented by a district society in this manner, nominations shall be made from the floor.

Now Reads:

Sec. 3. The Secretary-Treasurer shall have prepared in advance an official ballot. One ballot shall be given to each active

voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in a locked ballot box provided by the Secretary-Treasurer and kept in the custody of the Tellers designated by the President. The key shall be kept by the Chairman of the Tellers.

Sec. 4. Voting shall take place during the hours of the scientific program up to 10:30 a. m. of the last day of the annual session. At that time the Committee of Tellers appointed by the President shall count the ballots and report their findings to the members at the last meeting of the Association. The candidate for President-Elect receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select the President-Elect from the two candidates having the highest number of votes by secret ballot. Other officers shall be elected by receiving the highest number of votes on the first ballot.

Sec. 5. Delegates and Alternates to the American Medical Association shall be elected in the same manner and at the same time and in accordance with the Constitution and By-Laws of the American Medical Association.

Will Read:

SEC. 3. METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SEC. 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the Annual Session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

SEC. Delegates and Alternates to the American Medical Association shall be elected in the same manner and at the same time and in accordance with the Constitution and By-Laws of the American Medical Association.

Now Reads:

CHAPTER VI.

Duties of Officers

Sec. 1. The President. The President shall preside at the organization meeting of the House of Delegates and at all meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an address at such time during the annual session as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession and of the Association in the State during his term of office. So far as practicable he shall visit by appointment the various district societies, and shall assist the Councilors in building up the county societies, and in increasing the prestige of the Association. He shall be a member of the Council and its Executive Committee, and shall be a member of all committees of the Association with the authority to call a meeting of any Committee when necessity demands it or after failure of the chairman to do so. With the consent of the Council he shall terminate any committee whose function has been fulfilled. It shall be his duty with the approval of the Council, to replace any member of any committee who fails to show interest in performing the duties assigned to him.

Will Read:

CHAPTER VI.

Rights and Duties of Officers

SEC. 1. PRESIDENT. The President shall (A) preside at all general meetings of the Association; (B) address the opening General Session of the Annual Session; (C) assist the Councilors in improving the county and district societies as far as practicable; (D) serve as a member of Council and as a member of its Executive Committee; (E) serve as a member of all committees of the Association with the authority to call a meeting of any committee when necessity demands it or after failure of the chairman to do so. With the approval of Council, he may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned to him; (F) he shall be an *ex-officio* member of the House of Delegates without the right to vote.

Now Reads:

Sec. 2. The President-Elect. The President-Elect shall be a member of the Council, and shall be a member *ex-officio* of all standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and the Standing Committees.

Will Read:

SEC. 2. PRESIDENT-ELECT. The President-Elect shall be a member of the Council and of its Executive Committee, and shall be a member *ex-officio* of all standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and, when possible, the standing committees. He shall be an *ex-officio* member of the House of Delegates without the right to vote.

Now Reads:

Sec. 4. The Secretary-Treasurer. (a) The Secretary-Treasurer or his representative shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and its Executive Committee and an *ex-officio* member of all committees.

Sec. 4. (b) He shall be custodian of all record books and papers belonging to the Association and shall keep account of all funds of the Association which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each, his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall supply all component societies with the necessary blanks for making their annual reports, and shall collect the regular per capita assessments from the component societies. The amount of his salary shall be fixed by the Council.

Will Read:

SEC. 4. (A) SECRETARY. The Secretary or his representative shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be Secretary of the Council and its Executive Committee and an *ex-officio* member of the House of Delegates and all committees of the Association.

SEC. 4. (B) He or the Executive Secretary shall be custodian of all record books and papers belonging to the Association. He shall provide for the registration of the members and delegates at the Annual Session. He shall, with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall supply all component societies with the necessary blanks for making their annual reports, and shall collect the regular per capita assessments from the component societies. The amount of his salary shall be fixed by the Council.

Additions to Chapter VI Will Read:

SEC. 5. IMMEDIATE PAST PRESIDENT. The Immediate Past President shall serve for one year immediately following his term of office as President. He shall serve on the Council and its Executive Committee and shall be an *ex-officio* member of the House of Delegates without the right to vote.

SEC. 6. SPEAKER. The Speaker of the House of Delegates shall serve for three years and shall preside over all meetings of the House of Delegates. It shall be his duty to preserve order and to follow the proper parliamentary procedures. It shall be the duty of the Speaker to have the representation of each component county society checked by the Committee on Credentials at the time of the Annual Session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy. He shall serve as a member of Council.

SEC. 7. VICE-SPEAKER. The Vice-Speaker of the House of Delegates shall serve for three years and shall preside over the House of Delegates in the absence of the Speaker. In the event of the Speaker's death, resignation or inability to serve, the Vice-Speaker shall succeed him for the unexpired term. He shall serve as a member of Council in the absence of the Speaker.

Now Reads:

CHAPTER VII.

Component County Societies and District Societies

Sec. 1. *County and District Societies.* All county and district societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state which have adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitution and by-laws shall have been submitted to the Council and received its approval. A component society shall consist of three or more active members.

Will Read:

CHAPTER VII.

Component County Societies

SEC. 1. COUNTY SOCIETIES. All county societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state which have adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval. A component society shall consist of three or more active members.

Now Reads:

Sec. 2. *Charter.* Upon application to and recommendation by the Council, the House of Delegates shall provide and issue charters to county and district medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary-Treasurer. The House of Delegates shall have authority to revoke the charter of any component county society or district society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws. Only one component county society shall be chartered in each county.

Will Read:

SEC. 2. CHARTER. Council shall provide and issue charters to county medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws. Only one component county society shall be chartered in each county.

Now Reads:

Sec. 3. *Names of Societies.* The name and title of each component county society and district society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of The Medical Association of Georgia.

Sec. 4. *Custody of Charter.* The charter of each component county society and district society as issued by The Medical Association of Georgia, shall be preserved and shall be in the custody of the secretary of such society at all times.

Will Read:

SEC. 3. NAMES OF SOCIETIES. The name and title of each component county society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of The Medical Association of Georgia.

SEC. 4. CUSTODY OF CHARTER. The charter of each component county society as issued by the Medical Association of Georgia, shall be preserved and shall be in the custody of the secretary of such society at all times.

Now Reads:

Sec. 5. *Constitutions and By-Laws.* Each component county society and district society shall have a constitution and by-laws. These shall be in conformity with the Constitution and By-Laws of The Medical Association of Georgia, and a copy thereof shall be transmitted to the headquarters of The Medical Association of Georgia for approval and record.

Sec. 6. *Purposes and Duties.* Each component county society shall have general direction of the affairs of the profession in the county and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

Sec. 7. *Official Records.* The official copy of the constitution and by-laws of each component county society shall be kept in

a special book provided for that purpose. In it shall be entered all amendments which have been notified by the Council of The Medical Association of Georgia. It shall contain the signature of each member who is entitled to membership in The Medical Association of Georgia, together with the date of his election, decease, resignation or expulsion. It shall be the duty of the secretary to preserve this book and hold it available when required for reference.

Will Read:

SEC. 5. PURPOSES. Each component county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county or counties in its jurisdiction.

SEC. 6. DUTIES. Each component county society shall meet the following five minimum standards: Each society shall (1) meet a minimum of four times a year, elect officers and delegates annually at a meeting before January 1st and report these officers to the headquarters office before January 1st; (2) maintain an up to date Constitution and By-Laws in conformity with the Constitution and By-Laws of the Medical Association of Georgia and shall transmit a copy of its Constitution and By-Laws to the headquarters office for approval and record; (3) maintain a Board of Censors and/or a Mediation Committee; (4) maintain minutes of each meeting in a permanent record book that will be available at all times; (5) maintain at its minimum four meetings annually scheduled programs.

Now Reads:

Sec. 8. *Delegates and Alternates.* Each component county society at its annual meeting shall elect delegates and alternates to represent it in the House of Delegates of the Association in accordance with these By-Laws, unless other definite procedure for the selection of delegates is provided in its constitution and by-laws. The secretary of each component county society shall send a list of such delegates to the Secretary-Treasurer of the Association at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with these provisions. In the absence of, or the disability or disqualification of a delegate, the vacancy shall be filled by the President from other members of the same component county society.

Will Read:

SEC. 7. DELEGATES. Each component county society shall elect at its annual meeting prior to January 1st Delegates and Alternates to the House of Delegates in accordance with these By-Laws. The secretary of each component society shall send a list of such delegates to the Secretary of the Association before January 15th. In the absence of, or the disability or disqualification of, a Delegate, the vacancy may be filled by the President of the society from other members of the same component society, provided such vacancy is filled prior to the first session of the House of Delegates.

Now Reads:

Sec. 9. *Combined Counties.* The House of Delegates shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district or other classes of societies. Such societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for component county societies.

Sec. 10. *Annual Meeting.* Each component county society shall designate the meeting held nearest to January 1st of each year as its annual meeting, at which time delegates to the House of Delegates, and a local member of the sub-committee on Legislation and sub-committee on Public Health will be chosen, and their names forwarded promptly to the Secretary of the Association.

Sec. 11. *Purposes and Duties of District Societies.* District Societies shall have one or more meetings during the year. A Councilor and a Vice-Councilor shall be nominated at the appropriate annual meeting and forwarded to the Secretary of the Association to be elected by the Association for terms of three years in a rotating manner with other district societies. At the same time, each shall elect a member to the sub-committees on Legislation and Public Health of the Association.

Will Read:

SEC. 8. COMBINED COUNTIES. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies. These societies when

chartered shall be entitled to all the rights and privileges provided for component societies. A physician residing in a county not having a component society shall be referred to an adjacent component county society by Council.

SEC. 9. ANNUAL MEETING. Each component county society shall designate a meeting held prior to January 1st as its annual meeting, at which time Officers and Delegates for the next year shall be elected and their names forwarded before January 15th to the Secretary of the Association.

SEC. 10. DISTRICT SOCIETIES. District Societies shall have one or more meetings during the year and shall nominate a Councilor and Vice-Councilor as provided in these By-Laws. These district societies shall be organized for the best interests of the medical profession in Georgia and shall not necessarily conform with the boundaries of congressional districts. District societies shall elect officers, adopt a Constitution and By-Laws in conformity with the Constitution and By-Laws of the Medical Association of Georgia and levy dues for the government of its own affairs.

Now Reads:

(CHAPTER IV.)

Sec. 4. (c) *He shall give bond in the amount of a sum to be fixed by the Council. He shall receive all funds of the Association, together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at the last meeting of the fiscal year at the annual session of the Association. This shall consist of an itemized statement of all financial transactions of the past year, all accounts made, money received and disbursed with vouchers attached. The fiscal year includes the period of time between January 1st and December 31st. This financial report shall be published in The Journal as soon as practicable after the end of each fiscal year.*

Will Read:

CHAPTER VIII.

Funds and Expenditures

SEC. 1. TREASURER. The Treasurer shall be appointed annually by the Executive Committee of Council subject to the approval of Council. The Treasurer shall be a member in good standing for at least three years prior to his appointment and may be the same person as the Secretary. The Treasurer shall not be an officer of the Association but shall be an *ex-officio* member of Council and the House of Delegates without the right to vote. He shall be an *ex-officio* member of the Committee on Auditing and Appropriations. The Treasurer shall give bond in such sum as may be fixed by the Council, the premium on such bond to be paid by the Association.

SEC. 2. TREASURER'S DUTIES. The Treasurer shall receive all funds of the Association together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at its last meeting of the fiscal year. The fiscal year includes the period of time between January 1st and December 31st. A financial report shall be published in THE JOURNAL as soon as practicable after the end of each fiscal year. All checks for Association expenditures shall be signed by both the Treasurer and the Secretary, or by two officers of the Association designated by Council.

Now Reads:

CHAPTER VIII.

Dues and Assessments

Sec. 1. *The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the Secretary-Treasurer of the Association. Neither shall the Secretary-Treasurer of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.*

An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the

current year plus one year's dues in arrears subject to reapplication and approval by his county society.

Sec. 2. *The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.*

Sec. 3. *For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.*

Sec. 4. *Any county society which fails to make the reports required before the annual session of the Association, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.*

Will Read:

SEC. 3. (a) DUES AND ASSESSMENTS. The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the active members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association before January 1st the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the headquarters office of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the headquarters office of the Association. Neither shall the headquarters office of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.

An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval by his county society.

SEC. 3. (b) The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

SEC. 3. (c) For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

SEC. 3. (d) Any county society which fails to make the reports required before the annual session of the Association shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

Now Reads:

CHAPTER IX.

Standing Committees

Sec. 1. *The Standing Committees of the Association shall be as follows:*

- (A) *Committee on Scientific Work*
- (B) *Committee on Legislation*
- (C) *Committee on Medical Education*
- (D) *Committee on Medical Defense*
- (E) *Committee on Professional Conduct*
- (F) *Committee on History and Vital Statistics*
- (G) *Committee on Public Health*
- (H) *Committee on Maternal and Infant Welfare*
- (I) *Committee on Rural Health*
- (J) *Committee on Industrial Health*
- (K) *Committee on Public Relations*
- (L) *Committee on Cancer*
- (M) *Committee on Insurance*
- (N) *Committee on Veterans Affairs*
- (O) *Committee on Constitution & By-Laws*
- (P) *Committee on Awards*
- (Q) *Committee on Woman's Auxiliary*
- (R) *Committee on Hospitals*

CHAPTER IX.

Standing Committees

SEC. 1. The Standing Committees of the Association shall be as follows:

- (A) Committee on Scientific Work
- (B) Committee on Legislation
- (C) Committee on Medical Education
- (D) Committee on Medical Defense
- (E) Committee on History and Vital Statistics
- (G) Committee on Public Health
- (H) Committee on Maternal and Infant Welfare
- (I) Committee on Rural Health
- (J) Committee on Industrial Health
- (K) Committee on Public Service
- (L) Committee on Cancer
- (M) Committee on Insurance and Economics
- (N) Committee on Veterans Affairs
- (O) Committee on Constitution & By-Laws
- (P) Committee on Scientific Awards
- (Q) Committee on Woman's Auxiliary
- (R) Committee on Hospitals
- (S) Committee on Crawford W. Long Memorial Hospital
- (T) Committee on Mental Health

Now Reads:

Sec. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. One member of each standing committee shall be appointed each year by the President to serve for three or more years as required by each committee and announced at the time of the final meeting of the Association each year. Provided that for the first year the President shall appoint three or more members as required with one member to serve for the necessary graduated period of years to meet these requirements. Failure of a member to carry out the duties of his committee assignment during any year shall automatically cause his removal at the time of the annual session and the President, with the consent of the Council, shall appoint another member to fill his unexpired term. All committees shall make an annual report in writing to the Association headquarters office sixty days in advance of the Annual Session.

Will Read:

SEC. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three year. Unless otherwise provided in these By-Laws, Executive Committee of Council shall appoint standing committee members and standing committee chairmen as needed. One member of each standing committee shall be appointed each year by the Executive Committee of Council to serve for three years. The Executive Committee shall make all appointments at least 30 days prior to the Annual Session and all standing committees shall hold their organizational meeting at the time of the Annual Session. The members of each committee shall serve staggered terms of office so that only one term shall expire each year. Failure of a member to carry out the duties of his committee assignment shall automatically cause his removal by the President on recommendation from the committee chairman, and, with the consent of Council, the President shall appoint another member to fill his unexpired term. All committee chairmen shall make an annual report in writing of not more than 500 words to the Association headquarters office 60 days in advance of the Annual Session for consideration by the House of Delegates.

Now Reads:

(A) The Committee on Scientific Work. The Committee on Scientific Work shall be composed of five members: the President, the Secretary-Treasurer and three members appointed for terms of three years each. The senior appointed member shall serve as chairman. The duties of the Committee on Scientific Work shall be to prepare and publish the Scientific Program of the annual session, subject to the approval of Council. It shall also prepare and publish all rules and regulations governing the selection and presentation of papers, discussions and Scientific Exhibits before the general meetings and shall present them for publication in The Journal of the Association.

The presentation of Scientific Exhibits for the annual session shall be under the direction of this committee. For this purpose, the committee may set up a sub-committee of three or more members with representatives from the two medical schools of the State.

All lectureships of the Association shall be under the control of this committee, but special sub-committees may be established to advise the committee concerning the selection of proper speakers for each lectureship. These special lectures shall be given

before the general meetings at a time selected by the Committee on Scientific Work.

Will Read:

(A) COMMITTEE ON SCIENTIFIC WORK. The Committee on Scientific Work shall be composed of six members: the President, the Secretary, the Chairman of the Auditing and Appropriations Committee and three members appointed for terms of three years each. The senior appointed member shall serve as chairman. The duties of the committee shall be to prepare and publish the Scientific Program of the Annual Session, subject to the approval of Council. It shall make all rules and regulations governing the selection and presentation of papers, discussions and scientific exhibits before the general meetings. It may divide the scientific work into whatever number of sections that seem advisable for the particular Annual Session. As each section becomes established it shall elect its own officers subject to such rules and regulations as may be laid down by the Committee on Scientific Work.

All lectureships of the Association shall be under the control of this committee, but special sub-committees may be established to advise the committee concerning the selection of proper speakers for each lectureship. These special lectures shall be given before the general meetings at a time selected by the Committee on Scientific Work.

Now Reads:

(B) The Committee on Legislation. The duties of the Committee on Legislation shall be to represent the Association in securing and enforcing legislation in the interests of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local and national affairs. It shall further the education of the general public in health matters fostering a sane point of view about proper medical care.

Each component county society and district society shall designate one member at its annual meeting to serve with the Committee on Legislation in an active capacity. Vacancies in this special sub-committee shall be filled by the President. In addition, the Woman's Auxiliary shall be requested to form a similar committee with representatives from each component auxiliary. The President may appoint for one year an Advisory Committee of any number he deems advisable.

Will Read:

(B) COMMITTEE ON LEGISLATION. The Committee on Legislation shall be composed of a chairman, who shall have charge of matters pertaining to State of Georgia legislation; a vice-chairman, who shall have charge of matters pertaining to legislation of the Congress of the United States; three other members and the chairmen of the following committees: Medical Education, Public Health, Maternal and Infant Welfare, Rural Health, Industrial Health, Insurance, Veterans Affairs, Hospitals and Mental Health. The President of the State Board of Medical Examiners and the Chairman of the State Board of Health shall also be members of the committee. The duties of the committee shall be to represent the Association in securing and enforcing State of Georgia and Federal legislation in the interests of public health and scientific medicine. The committee shall meet at least 60 days prior to the convened sessions of either the Georgia General Assembly or the Congress of the United States. The committee shall appoint at least 10 keymen, one from each congressional district, to represent the committee in their area on matters pertaining to legislation of the Congress of the United States. As many other keymen as are needed shall be appointed to represent the committee on matters pertaining to State of Georgia legislation.

Now Reads:

(G) The Committee on Public Health. The Committee on Public Health shall be assisted by a sub-committee of one member elected by each county and district society of the state. Its duty shall be to advise with the Governor and other State officials, and with the Georgia State Board of Health and other related groups in regard to all matters concerning the health of the citizens of Georgia. It shall meet at the time of each session of the Georgia State Legislature with the Committee on Legislation to give assistance in carrying out its duties.

The President may appoint for one year an Advisory Committee of any number he deems advisable.

Will Read:

(G) THE COMMITTEE ON PUBLIC HEALTH. The Committee on Public Health shall be composed of a chairman and a member of the Georgia State Department of Health appointed by the Executive Committee of Council of the Medical Association of

Georgia and the chairman of each of the following Association committees: Industrial Health; Rural Health; Hospitals; Legislation; Medical Civil Preparedness; Mental Health; Crippled Children; Maternal and Infant Welfare; Chronic Illness; Cancer; Insurance Board; and Blood Banks. The chairmen of these committees shall then automatically be members of the Association's Public Health Committee and shall select an alternate member from each of their respective committees to represent them at Public Health Committee meetings in the absence of the chairman. It shall be the duty of the Public Health Committee to meet at least annually to hear reports from the committee chairmen members so named, to correlate their activities and to act as a "clearing house" for any matters concerning public health. It shall also be the duty of the Public Health Committee to correlate these activities with the Georgia Department of Public Health."

Now Reads:

(H) *The Committee on Maternal and Infant Welfare shall be composed of seven members, three of whom shall be general practitioners. It shall regularly review and analyze the causes of all maternal deaths occurring in the State. It shall investigate conditions affecting maternal care in Georgia and make recommendations concerning improvements thereof. It shall establish a working liaison with the Georgia State Obstetrical and Gynecological Society and the Georgia Pediatric Society and shall consider the establishment of annual post-graduate regional courses in obstetrics throughout the State with the cooperation of the Committee on Medical Education and Hospitals.*

Will Read:

(H) COMMITTEE ON MATERNAL AND INFANT WELFARE. The Committee on Maternal and Infant Welfare shall be composed of three or more general practitioners, three or more obstetricians and three or more pediatricians. Terms of office shall be for a period of three years with one third of the members appointed annually by the Executive Committee of Council. The committee shall regularly review and analyze the causes of all maternal deaths and perinatal losses occurring in the State for the purpose of recommending improvement. It shall also investigate conditions affecting maternal and infant care in Georgia and make recommendations concerning improvements thereof. The committee shall meet a minimum of twice annually.

Now Reads:

(K) *The Committee on Public Relations shall be appointed by the President. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.*

Will Read:

(K) THE COMMITTEE ON PUBLIC SERVICE shall be appointed by the Executive Committee of Council. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.

Now Reads:

(M) *The Committee on Insurance or Insurance Board shall consist of not less than five members appointed for a period of five years in rotation by the President. The committee may elect one of its members to be chairman or request the President to designate a member as chairman. Members appointed during the first four years shall serve staggered terms as designated by the President.*

The four geographical quadrants and the central industrial area shall have representation on this committee. Also the chairman may nominate five lay persons with known interest in the field of insurance for appointment by the President, who shall serve with the Board in an advisory capacity.

It shall be the duty of this committee to formulate and administer all policies and plans pertaining to insurance insofar as such concern members of the Association. In particular it shall sponsor and promote the Georgia Plan including provision for necessary expenses.

Will Read:

(M) COMMITTEE ON INSURANCE AND ECONOMICS. The Committee on Insurance and Economics or Insurance Board shall

consist of not less than 10 members, one from each councilor district, to be appointed for a period of three years in rotation by the Executive Committee of Council and the Executive Committee shall appoint one of these chairman. The chairman may nominate lay persons with known interest in the field of insurance for appointment by the Executive Committee to serve in an advisory capacity.

It shall be the duty of this committee to formulate and administer all policies and plans pertaining to insurance insofar as such concern members of the Association. In particular it shall sponsor and promote the Georgia Plan including provision for necessary expenses.

Now Reads:

(P) *The Committee on Awards shall have complete charge of all awards made by the Association or in the name of the Association. The decisions of this Committee shall be final in reference to recipients.*

Will Read:

(P) THE COMMITTEE ON SCIENTIFIC AWARDS shall have complete charge of all awards made by the Association or in the name of the Association for scientific exhibits at the Annual Session.

Additions as Follows:

(S) COMMITTEE ON CRAWFORD W. LONG MEMORIAL. The Committee on Crawford W. Long Memorial shall supervise matters pertaining to the Crawford W. Long Memorial and shall represent the Association in such matters subject to the approval of Council.

(T) COMMITTEE ON MENTAL HEALTH. The Committee on Mental Health shall promote the welfare of the mentally ill in the state of Georgia and shall constantly seek means of improving care for the mentally ill in the state.

Now Reads:

CHAPTER XI.

The Journal

Sec. 1. *The Journal of the Medical Association of Georgia herein referred to as The Journal, shall be under the control and direction of the Council. It shall appoint an Editor, and an Editorial Board and make any other provisions for the publication of The Journal which in its judgment are necessary. Such appointee or appointees shall serve at the pleasure of the Council, which shall have full discretionary power to promulgate rules and regulations governing the publication of The Journal; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.*

Sec. 2. *The Council may employ a Business Manager of The Journal and other personnel and fix the terms of such employment.*

Sec. 3. *All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in The Journal. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.*

Will Read:

CHAPTER XI.

The Journal

SEC. 1. THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA herein referred to as THE JOURNAL, shall be under the control and direction of the Council. It shall appoint an Editor and an Editorial Board and make any other provisions for the publication of THE JOURNAL; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SEC. 2. The Council may employ a Business Manager of THE JOURNAL and other personnel and fix the terms of such employment.

SEC. 3. All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in THE JOURNAL. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

SEC. 4. The Executive Committee of the Council shall constitute the Publications Committee of THE JOURNAL.

Addendum

Your committee wishes to correct certain errors and unintentional omissions in its report as published. These occurred due to typographical or typesetting errors.

1. In Article IX, Section 4, of the *Constitution* the word "Vice-Councilors" was omitted twice. It should read: "Terms of Other Officers. Other officers shall be elected for terms of one year each except the Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, and the Councilors and Vice-Councilors, who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually. All officers shall serve until their successors are elected and installed."

5. In Section 7, Chapter III of the *By-Laws*, the first sentence should read: "For the purpose of expediting proceedings, the Speaker of the House of Delegates shall appoint from the members of the House of Delegates the reference committees, the credentials committee, and other committees considered necessary."

The remainder of Section 7 is correct.

3. Chapter IV, Section 1. In the sentence as relates to Vice-Speaker, the word "serve" was omitted. (Line 9, page 64, Delegates Handbook).

4. In Chapter IX, Section 1. (5) The word "Hospital" should be deleted. This was a misprint.

5. Following Chapter XI should appear Chapters XII, XIII, and XIV from the old *By-Laws* since the wording of these chapters was not changed.

Finally, since this revision of both Constitution and By-Laws we feel represents an integrated document, and in normal course of parliamentary procedure the By-Law recommendations could be passed at this session of the House of Delegates but in that event might be in conflict with the present Constitution, we recommend that the proposed revisions in the By-Laws not be acted upon until the House of Delegates meeting in 1956. At that time the House of Delegates can act as it wishes on the proposed entire document.

Reference Committee recommendation—The reference committee recommends that the addendum report on the Constitution and By-Laws be accepted as presented. The proposed Constitution was approved with the following additions and deletions for clarification as follows:

ARTICLES I - IV of the Constitution: no change as published in the Delegates Handbook.

ARTICLE V, Section 1: Delete words "and past Councilors" of line 4. The corrected article should read as follows: "Composition. The House of Delegates is composed of Delegates elected by the component county medical societies as provided in the By-Laws. The general officers, the past presidents of the Association, the Treasurer, Editor of the Journal, Delegates to the AMA, the Executive Secretary and Chairmen of Standing Committees shall be ex-officio members of the House of Delegates without the right to vote."

ARTICLE X was approved with the addendum report read before the first meeting of the House of Delegates Sunday afternoon. Article X should read as follows: "Terms of Other Officers. Other officers shall be elected for terms of one year each, except the Secretary, Speaker of House of Delegates, Vice-Speaker of the House of Delegates and the Councilors and Vice-Councilors, who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually. All officers shall serve until their successors are elected and installed."

The committee recommends no other changes in the proposed Constitution.

The proposed By-Laws (which are to be held until next year for their passage along with the second reading of the Constitution per the addendum report) were approved as follows:

CHAPTER I, Section 4: Addendum to be added at the end of Section 4 as follows: "nothing in this section shall be construed to be retroactive to affect previously elected life members."

CHAPTER III, Section 1: Delete words "as may be determined by Council" in line 5.

CHAPTER III, Section 7: First sentence of Section 7 should read as follows: "For the purpose of expediting proceedings, the Speaker of the House of Delegates shall appoint from the members of the House of Delegates, the reference committees, the credentials

committee and other committees considered necessary."

CHAPTER IV, Section 1: The change should be as follows: the word "serve" was omitted on line 9, and it should read as follows: "CHAPTER IV, Section 1: Composition. The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice-Presidents, the Secretary, Speaker of the House of Delegates or the Vice-Speaker of the House of Delegates and one Councilor or Vice-Councilor from each councilor district. Vice-Councilors shall be ex-officio members of Council, except in the absence of their respective Councilors when they shall serve as Councilors. The Vice-Speaker shall be an ex-officio member of Council, except in the absence of the Speaker, then he shall serve in the Speaker's stead. The Treasurer, Editor of the Journal, Executive Secretary, and Delegates to the AMA shall be ex-officio members of Council without the right to vote."

CHAPTER IV, Section 4: Delete word "apart" in line 3. It should read as follows: "Meetings. The Council shall meet at the close of the Annual Session to organize and at intervals of not more than four months until the next Annual Session. Special meetings of the Council may be held on the call of the president or upon the request of three members of Council. Regular meetings of Council will be held on the call of the chairman."

CHAPTER VII, Section 6: Insert the word "with" in the last line between the words annually and schedule.

CHAPTER VIII, Section 2: Correct the reading of line 6 as follows: The fiscal year includes the period of time from January 1 through December 31."

CHAPTER IX, Section 1: Correct the listing of committees as follows: Committee E should read "Committee on Professional Conduct" and F should read "Committee on History and Vital Statistics." Furthermore in item F: Delete the word "hospitals."

Following Chapters XI, should appear Chapters XII, XIII, and XIV from the old By-Laws since the wording of these chapters was not changed.

The committee also suggests to the president that this same committee be continued at the next Annual Session to complete this work.

Certain suggestions made by Allen H. Bunce, Atlanta, were received by the committee, and were used by the committee and also referred to the Committee on Constitution and By-Laws for their appraisal and guidance.

The reference committee also approved the changes in the Constitution and By-Laws proposed at the 1954 Annual Session of the Medical Association of Georgia and presented to Reference Committee No. 6 for their deliberation and to be brought before the House of Delegates at the Annual Session, 1955, for the second reading which constitutes their going into effect as of this day.

House of Delegates action—Recommended the adoption of the Constitution and By-Laws Committee report, with the Addendum, and with the suggestions and alterations and additions or deletions of the reference committee as presented by the reference committee which was moved, seconded, and adopted.

The proposed changes in the Constitution submitted to the 1954 House of Delegates at the Annual Session and read for the second time before the 1955 House of Delegates at the Annual Session are as follows:

AMENDMENTS TO CONSTITUTION

First Read and Approved at the 1954 Annual Session, Macon, May 2-5, 1954

ARTICLE VI COUNCIL

Sec. 2. The Council shall consist of the President, President-Elect, the immediate Past-President, the Secretary-Treasurer, and one Councilor from each Congressional District in the State of Georgia.

ARTICLE IX OFFICERS

Sec. 1. Officers. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, Secretary-Treasurer, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, and one Councilor and a Vice Councilor from each of the Councilor Districts.

Sec. 3. Terms of Officers . . . Other Officers shall be elected for terms of one year each, except the

Secretary-Treasurer, the Councilors and Vice Councilors, who shall serve for three years. One-third, or as near as may be, of the Councilors and Vice Councilors shall be elected annually.

ARTICLE X FUNDS AND EXPENSES

The Council shall submit an annual budget for the next succeeding fiscal year to the House of Delegates. This budget shall not exceed the anticipated current income for the period covered by it. The Council shall manage the finances of the Association and shall supervise all funds, investments and expenditures of the Association. All resolutions providing for appropriations, recommended by the Council, shall be included in the annual budget, subject to final approval of the House of Delegates.

ARTICLE XI OFFICIAL PUBLICATION

The official publication of the Association shall be the *Journal of the Medical Association of Georgia*, in which shall be published all official Association notices, abstracts of transactions of the House of Delegates and general meetings of the Association, the annual budget, complete financial report as directed by Council, and abstracts of meetings of Council.

House of Delegates action—These changes are approved by the House of Delegates at this time, and herein are in effect, which was moved, seconded, and adopted.

Speaker Goodwin then read the list of eligible members before the House of Delegates for the election to Life Membership.

T. C. Clodfelter, Milledgeville; George L. Echols, Milledgeville; A. L. Horton, Cartersville; G. W. Willis, Ocilla; James C. Anderson, Macon; Carl L. Anderson, Macon; C. L. Ridley, Sr., Macon; H. L. Barker, Carrollton; O. W. Roberts, Carrollton; D. A. Bagley, Austell; J. R. Wallis, Lovejoy; B. O. Quillian, Douglas; L. H. Shellhouse, Willacoochee; W. B. Harrison, Athens; John Hunnicutt, Athens; R. F. Wheat, Bainbridge; W. S. Cook, Albany; I. M. Lucas, Albany; James A. Redfearn, Albany; N. R. Thomas, Albany; Clifford Moore, Sr., Lindale; George B. Smith, Rome; B. T. Beasley, Atlanta;

John B. Fitts, Atlanta; Patrick M. Howard, Atlanta; Kimsey E. Foster, College Park; James R. McCord, Atlanta; Henry W. Minor, Atlanta; Malcolm E. Noel, Atlanta; Cosby Swanson, Atlanta; Dan Y. Sage, Atlanta; Thomas Brabson, Cornelia; George T. Harper, Dewy Rose; V. H. Bennett, Gay; W. P. Ellis, Chipley; R. B. Gilbert, Greenville; F. M. Martin, Shellman; L. Fielding Lanier, Sylvania; E. J. Smith, Hahira; M. M. Head, Zebulon; Joseph C. Logan, Plains; A. C. Colson, Glennville; C. W. Harvey, Hogansville; J. C. Morgan, Sr., West Point; H. F. Shields, Chickamauga; Orlando S. Wood, Washington, and Robert C. Stephens, Washington.

By unanimous action of the House of Delegates, the above members were elected to Life membership at this session.

Speaker Goodwin then called for any unfinished business before the House of Delegates. It was moved, duly seconded, and approved that the matter of the General Practitioner of the Year as elected at the first session of this House of Delegates be referred to Council for action concerning the forwarding of the candidate's name to the American Medical Association for the American Medical Association Award of the General Practitioner of the Year.

Speaker Goodwin then called for any new business before the House of Delegates, after stating that no action could be taken on new business except under emergency circumstances. Speaker Goodwin further stated that in the absence of emergency circumstances, the chair would receive new business before the House for information only. Mr. Krueger was recognized, and he stated his appreciation to all of the reference committees and the secretaries for their cooperation with the headquarters staff in making possible the efficient and expeditious presentation of their reports.

A motion was duly made, seconded, and approved that the House of Delegates express its appreciation to Mr. Krueger, Mr. Kiser, Miss Franklin, Miss Porcher, Miss Richards, Miss Sanders, and all of the other headquarters office staff people connected with the meeting.

A motion was duly made, seconded, and approved to express the appreciation of the members of the House to the speaker and the vice-speaker for the excellent manner they had handled the business of this session. The speaker then entertained a motion for adjournment which was duly made, seconded, and approved.

Final General Business Meeting

WEDNESDAY, MAY 4, 1955

President Peter B. Wright called the meeting to order at 10:30 a.m.

President Wright then presented the Fifty Year Certificates to the following members: J. B. Baird, Atlanta; W. G. Bannister, Rome; J. A. Combs, Atlanta; V. L. Darby, Vidalia; William B. Harrison, Athens; S. M. Martin, Shellman; W. R. McCall, LaGrange; William L. Moss, Athens; Joel L. Porter, Rutledge; B. O. Quillian, Douglas; John W. Simmons, Brunswick; Cosby Swanson, Atlanta; John C. Verner, Commerce; Robert F. Wheat, Bainbridge; A. J. Whelchel, Cordele; Y. H. Yarborough, Milledgeville.

President Wright called on Mr. Lamartine G. Hardman, Jr. of Commerce, Georgia, to present the Hardman Award. This award, sponsored by Mr. Hardman and the Hardman family, was presented to V. P. Sydenstricker of Augusta. The Award was received for Dr. Sydenstricker by David R. Thomas, Jr., of Augusta.

President Wright then called upon the secretary, David Henry Poer, to present the Certificates of Appreciation. These Certificates of Appreciation were presented to the following persons: J. C. Weaver, Atlanta; Mrs. Shelley C. Davis, Atlanta; J. W. Chambers, LaGrange; Marion C. Pruitt, Atlanta; Peter B. Wright,

Augusta; Mr. Lamartine G. Hardman, Jr., Commerce; and the Professional Service Representatives Association.

President Wright called on Hoke Wammock, Augusta, Chairman of the Awards Committee, to present the Scientific Exhibit Awards. Chairman Wammock announced the following awards.

First Place—"The Anatomy of Bronchoscopy," Walter Faust Durden, William D. Logan, and William A. Hopkins, Atlanta, and the Department of Surgery of Grady Memorial Hospital, Atlanta.

Second Place—"Photographic and Transparent Sheet Reconstruction of Early Human Embryo," Chester H. Heuser, Ph.D., Professor of Microscopic Anatomy, Medical College of Georgia, Augusta.

Third Place—"The Diagnosis and Management of Diaphragmatic Hernias," Robert H. Vaughan, George M. Hutto, Randall Bradshaw, and George Epps, Columbus.

President Wright then turned the chair over to the first vice-president, Willard R. Golsan.

First Vice-President Golsan called upon Thomas Goodwin, Augusta, for the presentation of the President's Key to the outgoing president, Peter B. Wright of Augusta. Dr. Goodwin addressed the assembly and presented the President's Key to Dr. Wright. Secretary David Henry Poer then presented Dr. Wright with a bound volume of the *Journals* published during Dr. Wright's 1954-55 term of office and an honorarium for the president's expenses as stated in the Association Constitution and By-Laws.

First Vice-President Golsan then called on Phinizy Hitchcock, Chairman of the Golf Committee, Augusta, to present the golf prize awards.

The next order of business concerned the selection of the 1956 meeting place, and a motion by the Fulton County delegation was duly seconded and approved

that the 1956 Annual Session of the Medical Association of Georgia be held in Atlanta.

Dr. Golsan then called on Ralph Chaney, Chairman of the Tellers Committee for the election results.

Dr. Chaney announced the following results as the official tally of the balloting during the 1955 Annual Session.

President-Elect—Hal M. Davison, Atlanta

First Vice-President—Robert C. McGahee, Augusta

Second Vice-President—Stephen W. Brown, Augusta

AMA Delegate—C. H. Richardson, Sr., Macon

AMA Alternate Delegate—C. L. Ayers, Toccoa

First District Councilor—Lee Howard, Sr., Savannah

First District Vice-Councilor—Charles T. Brown, Guyton

Second District Councilor—George R. Dillinger, Thomasville

Second District Vice-Councilor—J. Z. McDaniel, Albany

Third District Councilor—W. G. Elliott, Cuthbert

Third District Vice-Councilor—Luther H. Wolff, Columbus

Fourth District Councilor—J. W. Chambers, LaGrange

Fourth District Vice-Councilor—Clarence B. Palmer, Covington

The next order of business was the installation of new officers.

Secretary Poer gave a breakdown on the number of physicians, members, guests, and exhibitors as follows: MAG Members—668; Non-Member Physicians—113; Medical Students—200; Visitors—30; Commercial Exhibitors—133; giving a grand total registration of 1,144.

President H. Dawson Allen then asked for a motion to adjourn which was duly made, seconded, and adopted.

1954-55 Council Meeting

Augusta, May 1, 1955

The final meeting of the 1954-55 Council of the Medical Association of Georgia was held at 10 a.m., Sunday, May 1, 1955, Bon Air Hotel, Augusta, Georgia, during the 105th Annual Session.

The following officers were present: Peter B. Wright, Augusta; Willard R. Golsan, Macon; Milford B. Hatcher, Macon; David Henry Poer, Atlanta; H. Dawson Allen, Milledgeville. Councilors present were Cheves, Schaefer, Elliott, Tift, Chambers, Wood, Dougherty, Howard, Yeomans, and Dillinger. Vice-Councilors present were Palmer, McDaniel, Brown, Fowler, Roule, and Andrews. AMA Delegates present were Eustace A. Allen and Spencer A. Kirkland. Also present were Thomas W. Goodwin, Augusta, Chairman of the Local Arrange-

ments Committee; Edgar Woody, Jr., Atlanta, Editor of the *Journal*; R. C. McGahee, and Stephen W. Brown, Augusta; the Messrs. Milton D. Krueger and John F. Kiser, of the headquarters office; and a special guest, George F. Lull, Secretary-General Manager of the AMA.

The meeting was called to order by Chairman Cheves. The invocation was given by Milford Hatcher.

Dr. Lull was introduced by Eustace A. Allen, and he presented a short discussion of national health legislation.

The Secretary then reviewed actions by Council during 1954-55.

Henry H. Tift, Macon, Chairman of the Special Com-

mittee on the Hardman Award, presented three nominations for the award—Virgil P. Sydenstricker, for his work in education, nutrition and anemia; Enoch Callaway, for his work in the field of cancer and education; and Kenneth S. Hunt, for his outstanding work on a community level.

On a motion (Wood-Hatcher) it was voted to present these three names to the House of Delegates.

Stephen W. Brown, Augusta, and R. C. McGahee, Augusta, then presented a report from Richmond County in regard to the operational policies for the Eugene Talmadge Memorial Hospital. A resolution recommending certain policies recently approved by the Richmond County Medical Society was presented, and it was voted to refer this resolution to the House of Delegates.

The Secretary then discussed the 1956 Annual Session. He also mentioned that a minutes book for each county society was being prepared, and this matter was referred to the Audit and Appropriations Committee.

J. W. Chambers, LaGrange, Chairman of the Constitution and By-Laws Committee, presented an addendum to his report which pointed out certain typographical errors in the new Constitution and By-Laws as printed in the Delegates Handbook. He also discussed a proposal that the new revised By-Laws be held in abeyance until the 1956 meeting when they could be passed with the Constitution as revised, thus making an entirely new consistent document at that time.

There being no further business the meeting was adjourned.

1955-56 Council Meeting

Augusta, May 4, 1955

The first organizational meeting of the 1955-56 Council of the Medical Association of Georgia was held at 11:30 a.m., Wednesday, May 4, at the Bon Air Hotel, during the 105th Annual Session of the Medical Association of Georgia, Augusta, Georgia.

Present were: President H. Dawson Allen, Milledgeville; President-elect, Hal M. Davison, Atlanta; Vice-Presidents Stephen W. Brown, Augusta and R. C. McGahee, Augusta; Secretary-Treasurer David Henry Poer, Atlanta; Councilors George R. Dillinger, Thomasville; Lee Howard, Sr., Savannah; D. Lloyd Wood, Dalton; Henry H. Tift, Macon; W. G. Elliott, Cuthbert; W. Bruce Schaefer, Toccoa; J. G. McDaniel, Atlanta (acting in absence of Mark S. Dougherty, Atlanta), and J. W. Chambers, LaGrange.

Also present were members of the Insurance Board—David R. Thomas, Jr., Augusta; W. L. Pomeroy, Waycross; John L. Elliott, Savannah; and D. Lloyd Wood, Dalton, who is also a member of Council. Also present were Fred H. Simonton, Chairman of the Scientific Work Committee, and the Messrs. Milton D. Krueger and John F. Kiser, of the MAG headquarters office.

The first order of business was the election of a chairman and vice-chairman.

On a motion (Dillinger-Elliott) J. W. Chambers of LaGrange was nominated for chairman and was duly elected.

On a motion (Cheves-Howard) George R. Dillinger of Thomasville was nominated for vice-chairman and was duly elected.

W. Bruce Schaefer, Toccoa, was elected chairman of the Audit and Appropriations Committee, replacing J. W. Chambers of LaGrange. The other two members of the committee, Mark S. Dougherty and D. Lloyd Wood, were reappointed.

The Executive Committee will consist of the president, immediate past president, president-elect, secre-

tary-treasurer, chairman of Council and chairman of the Audit and Appropriations Committee.

Council then heard from the Insurance Board in regard to the new professional liability insurance program. Membership of the Insurance Board was also discussed, and it was decided that the Insurance Board select its own chairman. The Board was also authorized to appoint lay persons as *ex-officio* members of the board.

Council then appointed a special committee, at the direction of the House of Delegates, to present the Richmond County Resolution in regard to the operation of Eugene Talmadge Memorial Hospital to the Board of Regents. This committee as appointed by Council is as follows: R. C. McGahee, Augusta, chairman; Alternate—Hubert Milford, Hartwell; Stephen W. Brown, Augusta; Alternate—B.L. Shackleford, Atlanta; J. G. McDaniel, Atlanta; Alternate—Fred H. Simonton, Chickamauga; A. B. Conger, Columbus; Alternate—H. Ansley Seaman, Waycross; Milford B. Hatcher, Macon; Alternate—Charles L. Prince, Savannah. Council also authorized any necessary expenditures to be made by this committee.

The next meeting of Council was set for May 29 in Atlanta at the Academy of Medicine, at 10 a.m. A meeting of the Audit and Appropriations Committee was called for Saturday, May 28, in Atlanta at the headquarters office.

Mark S. Dougherty of Atlanta was appointed chairman of the Council Committee on Arrangements for the 1956 meeting.

For information of Council, Fred H. Simonton, Chickamauga, then discussed plans for the scientific program for the 1956 meeting. He also discussed the possibilities of a program chairman committee meeting in June.

There being no further business the meeting was adjourned.

Auditors' Reports

December 31, 1955

REPORT OF EXAMINATION AND SUPPLEMENTARY DATA

THE MEDICAL ASSOCIATION OF GEORGIA — ATLANTA, GEORGIA

DECEMBER 31, 1954

ERNST & ERNST

Accountants and Auditors, Atlanta

Dr. H. L. Cheves
Chairman of The Council
The Medical Association of Georgia
Union Point, Georgia

We have examined the books of The Medical Association of Georgia for the year ended December 31, 1954, as maintained in the office of its Secretary and Treasurer. The scope of our examination included a test of the records of cash transactions for the year under review by comparisons of the totals of recorded cash receipts with deposits shown by monthly bank statements on file, and by inspection of paid checks, invoices, or other data on file in support of the recorded disbursements. Cash on deposit was reconciled with the amount reported to us by the depository bank. We also accounted for income of the Benevolent and Building Funds and the Abner Wellborn Calhoun Lectureship Fund for the year ended December 31, 1954, and the assets held in those funds at that date.

Statements of income and expense, by funds, for the year ended December 31, 1954, and a statement of assets and liabilities of the several funds as at that date are included herein.

Securities, comprising the entire assets of the Benevolent and Building Funds, are held in safekeeping by the Federal Reserve Bank of Atlanta and were confirmed by direct correspondence.

Assets of the Abner Wellborn Calhoun Lectureship Fund, consisting of cash and securities, were accounted for by direct correspondence with The Citizens and Southern National Bank, Atlanta, Georgia—Trustee.

The amount stated for accounts receivable is as shown by the books of the Association. We mailed statements to all debtors requesting confirmation of the balances at December 31, 1954, and no differences were reported in the replies received. The amount shown for accounts payable represents a listing of unpaid items on hand without further verification by us.

Travel deposit was confirmed by direct correspondence.

We examined policies evidencing the insurance protection of the Association at December 31, 1954, a summary of which is included herein.

Dues collected for and remitted to the American Medical Association during the year ended December 31, 1954, amounted to \$61,167.50, as shown by the books of the Association.

ERNST & ERNST
Certified Public Accountants

Atlanta, Georgia
February 24, 1955

STATEMENT OF EXCESS OF ASSETS OVER LIABILITIES — BY FUNDS

THE MEDICAL ASSOCIATION OF GEORGIA

Year ended December 31, 1954

	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
Excess of assets over liabilities at Dec. 31, 1953.....	\$ 8,869.91	\$63,320.00	\$ 5,986.99	\$78,176.90
Add:				
Adjustment of securities held in Benevolent and Building Funds to redemption values at Dec. 31, 1953	—	2,108.00	—	2,108.00
Net income for the year ended Dec. 31, 1954, as shown by statement of income and expense.....	11,547.79	494.00	270.43	12,312.22
EXCESS OF ASSETS OVER LIABILITIES —DEC. 31, 1954.....	<u>\$20,417.70</u>	<u>\$65,922.00</u>	<u>\$ 6,257.42</u>	<u>\$92,597.12</u>

NET INCOME FROM THE JOURNAL THE MEDICAL ASSOCIATION OF GEORGIA

Year ended December 31, 1954

INCOME

Advertising (less commissions paid).....				\$21,800.85
Subscriptions:				
Year 1954			\$11,195.77	
Prior years			85.00	11,280.77
TOTAL INCOME				<u>\$33,081.62</u>

EXPENSES

Salaries:				
Managing editor	\$ 3,900.00			
Other	1,200.00	\$ 5,100.00		
Publications expenses:				
Printing	\$20,674.99			
Cuts of illustrations.....	888.71			
Stationery	323.09			
Portion of general administrative expense.....	1,200.00			
Postage	545.00			
Pay roll tax	102.00			
Clipping service	196.20			
Addressograph service and supplies.....	186.20			
Copyright fees	48.00			
Sundry	105.07	24,269.26		29,369.26
NET INCOME				<u>\$ 3,712.36</u>

ADMINISTRATIVE AND OTHER EXPENSES

THE MEDICAL ASSOCIATION OF GEORGIA

Year ended December 31, 1954

Fixed allotments:				
Pensions		\$ 1,800.00		
Honorarium to president.....		1,000.00		
Legal fees		1,100.00		
Audit fee		575.00		
Contributions:				
Fulton County Medical Society.....	\$ 1,200.00			
Better Health Council of Georgia.....	1,200.00			
Woman's Auxiliary to the Association.....	1,300.00	3,700.00		
Insurance and bonds.....		113.15	\$ 8,288.15	

Headquarters' expense:		
Travel	\$ 3,835.82	
Meetings	359.59	
Stationery and printing	941.97	
Postage	610.91	
Telephone and telegraph	1,694.28	
Provision for depreciation	382.04	
Office supplies and expense	508.14	
Dues and subscriptions	203.61	
Janitor service	260.00	
Pay roll tax	314.20	
Portion of administrative expense charged to <i>The Journal</i>	1,200.00*	
Sundry	201.78	8,112.34
<hr/>		
Committee expense:		
Rural Health	\$ 382.29	
Medical Defense	96.27	
Legislation	174.21	
Maternal Welfare	126.68	
Industrial Health	97.00	
Public Relations	400.00	
Insurance and Economics	353.10	
Awards	99.72	
A. M. E. F.	10.92	
Veterans' Affairs	36.65	
Hospitals	32.80	
History and Vital Statistics	57.79	1,867.43
<hr/>		
Contingent fund:		
Christmas presents to employees	\$ 600.00	
Practitioner of the year biography, etc.	428.51	1,028.51
<hr/>		
TOTAL		<u>\$19,296.43</u>

*Indicates red figure.

BENEVOLENT AND BUILDING FUNDS — SECURITIES OWNED
THE MEDICAL ASSOCIATION OF GEORGIA
Year ended December 31, 1954

U. S. SAVINGS BONDS

	Cost	Face Amount	Redemption Value
SERIES F			
Due June 1, 1956	\$ 7,400.00	\$10,000.00	\$ 9,450.00
Due June 1, 1961	5,920.00	8,000.00	6,472.00
	<hr/>	<hr/>	<hr/>
	\$13,320.00	\$18,000.00	\$15,922.00
SERIES G			
Due July 1, 1957	\$15,000.00	\$15,000.00	\$14,595.00
Due March 1, 1959	15,000.00	15,000.00	14,460.00
Due January 1, 1960	15,000.00	15,000.00	14,370.00
Due January 1, 1962	5,000.00	5,000.00	4,735.00
	<hr/>	<hr/>	<hr/>
	\$50,000.00	\$50,000.00	\$48,160.00
TOTAL	<u>\$63,320.00</u>	<u>\$68,000.00</u>	<u>\$64,082.00</u>

NOTE—The Association has appropriated funds for benevolence and building as follows:

Benevolence	\$25,000.00
Building	35,000.00
TOTAL	<u>\$60,000.00</u>

ABNER WELLBORN CALHOUN LECTURESHIP FUND
(The Citizens and Southern National Bank, Atlanta, Georgia — Trustee)
THE MEDICAL ASSOCIATION OF GEORGIA

Year ended December 31, 1954

CASH HELD BY TRUSTEE

	Principal Cash	Income Cash	Combined
Balance at December 31, 1953.....	\$ 68.38	\$ 117.76	\$ 186.14
Receipts:			
Dividends received:			
Georgia Power Company:			
\$6.00 preferred stock	—	150.00	150.00
\$4.60 preferred stock	—	2.81	2.81
Atlanta Gas Light Company:			
4½ % preferred stock	—	85.52	85.52
American Bakeries Company:			
4½ % preferred stock	—	45.00	45.00
Cash received in exchange of 25 shares of Georgia Power Company \$6.00 preferred stock for 25 shares Georgia Power Company \$4.60 preferred stock	125.00	—	125.00
Transfer—Note A	245.12	245.12*	—
	<u>\$ 438.50</u>	<u>\$ 155.97</u>	<u>\$ 594.47</u>
Disbursements:			
Trustee's fee	\$ —	\$ 12.90	\$ 12.90
Purchase of 4 shares of Georgia Power Company \$4.60 preferred stock	426.00	—	426.00
	<u>426.00</u>	<u>\$ 12.90</u>	<u>\$ 438.90</u>
BALANCE AT DECEMBER 31 ,1954.....	<u>\$ 12.50</u>	<u>\$ 143.07</u>	<u>\$ 155.57</u>

SECURITIES HELD BY TRUSTEE

	Number of Shares	Market Value	Carrying Amount
American Bakeries Company—4½ % preferred stock.....	10	\$ 1,050.00	\$ 980.35
Atlanta Gas Light Company—4½ % preferred stock.....	19	1,976.00	1,971.50
Georgia Power Company—\$4.60 preferred stock.....	29	3,153.75	3,150.00
		<u>\$ 6,179.75</u>	<u>\$ 6,101.85</u>
TOTAL CASH AND SECURITIES AT DECEMBER 31, 1954.....			<u>\$ 6,257.42</u>

NOTE A—Under provisions of the trust indenture "all unexpended income in the hands of the Trustee on July 1st of each year shall be added to the principal of the trust fund".

*Indicates red figure.

ACCOUNTS RECEIVABLE
THE MEDICAL ASSOCIATION OF GEORGIA
Year ended December 31, 1954

EXHIBITORS AT 1955 ANNUAL MEETING

A. S. Aloe Company.....	\$ 300.00	
Brayten Pharmaceutical Company.....	150.00	
Bristol-Myers Products Division.....	75.00	
Creditors Mercantile and Adjustment Agency.....	150.00	
C. B. Fleet Company.....	150.00	
Harrower Laboratories.....	75.00	
Ives-Cameron Company.....	150.00	
Kremers-Urban Company.....	150.00	
Lederle Laboratories.....	150.00	
M. and R. Laboratories, Inc.....	75.00	
Maltbie Laboratories.....	150.00	
Parke, Davis and Company.....	150.00	
Wm. P. Poythress and Company.....	150.00	
The Stuart Company.....	150.00	
Surgical Supply.....	150.00	
U. S. Vitamin Corporation.....	150.00	
Van Pelt and Brown, Inc.....	150.00	
Wachtel's Physician Supply Company.....	150.00	\$2,625.00

FOR ADVERTISING IN THE JOURNAL

The New York Polyclinic Medical School and Hospital.....	\$ 47.60	
State Journal Advertising Bureau.....	1,109.54	
J. Walter Thompson Company.....	66.14	1,223.28

SUNDRY

Returned check.....		50.00
TOTAL		<u><u>\$3,898.28</u></u>

INSURANCE
THE MEDICAL ASSOCIATION OF GEORGIA
Year ended December 31, 1954

FIRE AND EXTENDED COVERAGE

Contents of building.....	\$4,000.00-A
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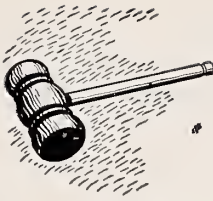
AUTOMOBILE—(non-owned cars)

Bodily injury.....	100/300,000.00
Property damage.....	5,000.00

FIDELITY BONDS

David Henry Poer.....	10,000.00
Thelma Viola Franklin.....	1,000.00

NOTE A—Loss payable to Dr. David Henry Poer, Secretary and Treasurer, The Medical Association of Georgia.



president's page

AS ONE AGES, if fortunate enough to have offspring, genealogy often becomes a major concern. This is understandable as we can look with more objectivity at the third generation of descent. Our questions are: How does the blood of tradition react to the moral forces of their time? What are the reflections cast by antecedents three generations back as viewed when we ourselves were young and filled with ideals and affections? Seeing the good and quickly forgetting the bad is our only system of ethics.

The fact that a new system of medical education is being born in Georgia may be causing too much concern with ethics. This system is new only as far as Georgia is concerned in that public education is being combined with public hospital care for teaching purposes; whereas in the remote past it was the public hospital that gave birth to medical schools as preceptorship failed. The Medical College of Georgia and the Eugene Talmadge Memorial Hospital as an integrated educational system is now without offspring, and we seem to be behaving as if we are shedding all of the traditions without a future for reflection.

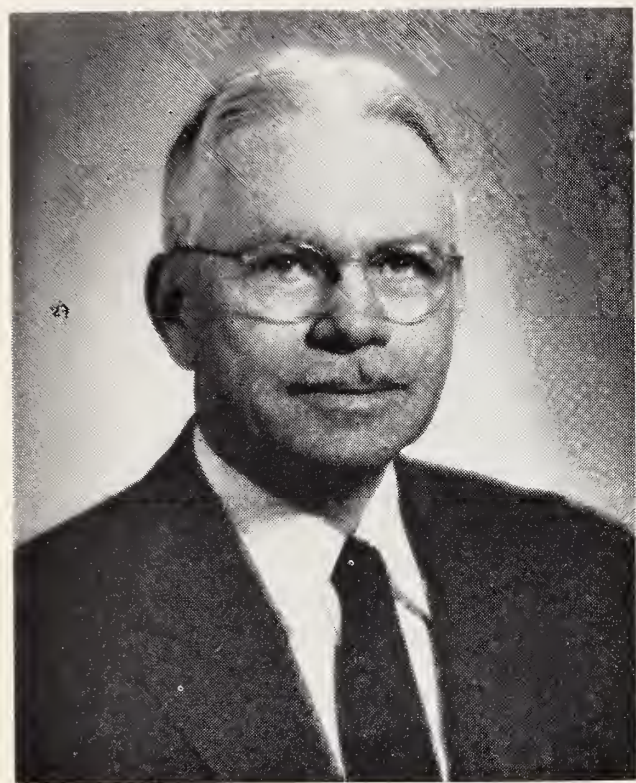
It was very fitting that the 1955 Annual Session of the Medical Association of Georgia should have been held in Augusta. I am indeed proud that I could have an official part in this meeting. Although our Public Relations Chairman, Chris McLoughlin, had anticipated at a regional level Dr. Lull's talk to the House of Delegates, it gave the necessary re-enforcement to the foundation of our Public Relations Program. Dr. Hess' address on ethics to the first general session was just what we needed. I liked the distinction he made between ethics and etiquette.

I cannot close this page without again realizing that the Richmond County Medical Society is still living up to all its traditions as a most hospitable and heart warming host.

H. D. Allen, Jr.

MAG Officers and Committees —

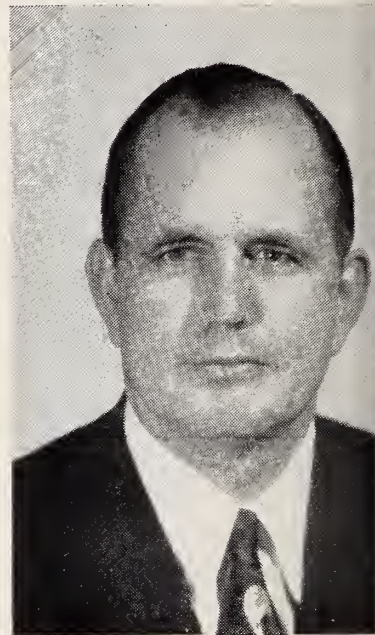
1955-1956



H. Dawson Allen, Jr.
President



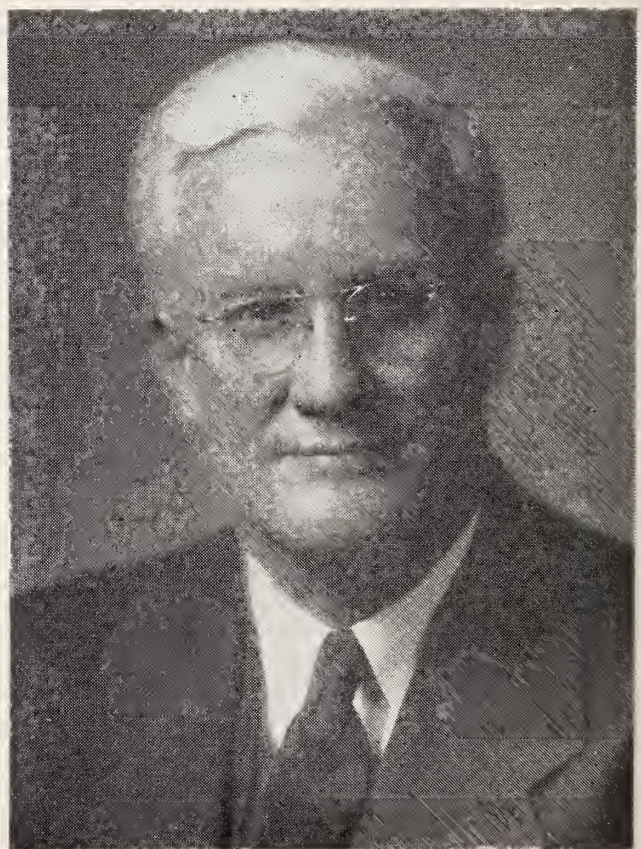
R. C. McGahee
1st Vice-President



Stephen W. Brown
2nd Vice-President



Hal M. Davison
President-Elect



David Henry Poer
Secretary-Treasurer

OFFICERS, 1955-1956

President—H. Dawson Allen, Jr., Milledgeville
President-Elect—Hal M. Davison, Atlanta
Immediate Past President—Peter B. Wright, Augusta
First Vice-President—R. C. McGahee, Augusta
Second Vice-President—Stephen W. Brown, Augusta
Secretary-Treasurer—David Henry Poer, Atlanta

Delegates to the A.M.A.

Terms Expire December 31, 1957

C. H. Richardson, Sr., Macon
C. L. Ayers, Toccoa, Alternate

Terms Expire December 31, 1956

Eustace A. Allen, Atlanta
William R. Dancy, Savannah, Alternate
Spencer Kirkland, Atlanta
Henry Tift, Macon, Alternate

Councilors

District	Term Expires
1—Lee Howard, Savannah	1958 Session
2—George R. Dillinger, Thomasville	1958 Session
3—W. G. Elliott, Cuthbert	1958 Session
4—J. W. Chambers, LaGrange, Chairman	1958 Session
5—Mark S. Dougherty, Jr., Atlanta	1956 Session
6—Henry H. Tift, Macon	1956 Session
7—D. Lloyd Wood, Dalton	1956 Session
8—Neal F. Yeomans, Waycross	1956 Session
9—W. Bruce Schaefer, Toccoa	1957 Session
10—H. L. Cheves, Union Point	1957 Session

Vice-Councilors

District	Term Expires
1—Charles T. Brown, Guyton	1958 Session
2—J. Z. McDaniel, Albany	1958 Session
3—Luther H. Wolff, Columbus	1958 Session
4—Clarence B. Palmer, Covington	1958 Session
5—J. G. McDaniel, Atlanta	1956 Session
6—H. G. Weaver, Macon	1956 Session
7—Ralph W. Fowler, Marietta	1956 Session
8—James M. Hicks, Brunswick	1956 Session
9—Charles R. Andrews, Jr., Canton	1957 Session
10—J. Victor Roule, Augusta	1957 Session

Executive Committee

H. Dawson Allen, Jr., Milledgeville, President
Peter B. Wright, Augusta, Immediate Past President
Hal M. Davison, Atlanta, President-Elect
David Henry Poer, Atlanta, Secretary-Treasurer
J. W. Chambers, LaGrange, Chairman of Council
W. Bruce Schaefer, Toccoa, Member of Council

Committee on Auditing and Appropriations

W. Bruce Schaefer, Toccoa, Chairman
D. Lloyd Wood, Dalton
Mark S. Dougherty, Jr., Atlanta

Honorary Advisory Board

J. W. Palmer	President, 1918-1919
C. K. Sharp	President, 1928-1929
William R. Dancy	President, 1929-1930
M. M. Head	President, 1932-1933
C. H. Richardson	President, 1933-1934
Clarence L. Ayers	President, 1934-1935
B. H. Minchew	President, 1936-1937
Grady N. Coker	President, 1938-1939
J. C. Patterson	President, 1940-1941
Allen H. Bunce	President, 1941-1942
James A. Redfearn	President, 1942-1943
W. A. Selman	President, 1943-1944
Cleveland Thompson	President, 1944-1946
Ralph H. Chaney	President, 1946-1947
Enoch Callaway	President, 1949-1950
A. M. Phillips	President, 1950-1951
W. F. Reavis	President, 1951-1952
C. F. Holton	President, 1952-1953
William Harbin	President, 1953-1954
Peter B. Wright	President, 1954-1955

STANDING COMMITTEES, 1955-56

(One member appointed annually to serve for 3 years—terms expire at Annual Session)

Scientific Work

Fred H. Simonton, Chickamauga, Chairman
H. C. Atkinson, Macon David Henry Poer, Atlanta
Thomas W. Goodwin, Augusta H. D. Allen, Jr., Milledgeville

Legislation

Grady N. Coker, Canton, Chairman
William Harbin, Rome, Co-Chairman
Carl C. Aven, Atlanta Jack C. Norris, Atlanta
Joseph D. McElroy, Atlanta Albert M. Deal, Statesboro

Medical Education

Edgar R. Pund, Augusta, Chairman
Harry B. O'Rear, Augusta J. K. Quattlebaum, Savannah
R. Hugh Wood, Emory U. Arthur P. Richardson, Emory U.

Medical Defense

Charles S. Jones, Atlanta, Chairman
David Henry Poer, Atlanta John McPherson, Jr., Athens
Perry P. Volpitto, Augusta

Professional Conduct

A. M. Phillips, Macon, Chairman
W. F. Reavis, Waycross William Harbin, Rome
C. F. Holton, Savannah Peter B. Wright, Augusta

History and Vital Statistics

J. Calvin Weaver, Atlanta, Chairman
Peter L. Scardino, Savannah Hoke Wammock, Augusta

Public Health

T. A. Sappington, Thomaston, Chairman
Duncan Shepard, Atlanta L. Minor Blackford, Atlanta
George T. Nicholson, Cornelia J. E. Scarborough, Atlanta
R. F. Spanjer, Cedartown David R. Thomas, Jr., Augusta
Grady N. Coker, Canton J. C. Thoroughman, Atlanta
Edgar M. Dunstan, Atlanta T. F. Sellers, Atlanta, Ex-Officio
Peter Hydrick, College Park Rives Chalmers, Atlanta
J. C. Hughston, Columbus

Maternal and Infant Welfare

Peter Hydrick, College Park, Chairman
Thomas C. McPherson, Atlanta Eugene L. Griffin, Atlanta
C. M. Mulherin, Augusta F. H. Simonton, Chickamauga
Helen W. Bellhouse, Atlanta George H. Alexander, Forsyth
Hugh J. Bickerstaff, Columbus James W. Bennett, Augusta

Woman's Auxiliary

Shelley C. Davis, Atlanta, Chairman
W. G. Elliott, Cuthbert Robert C. Major, Augusta
W. Bruce Schaefer, Toccoa

Constitution and By-Laws

J. W. Chambers, LaGrange, Chairman
Thomas W. Goodwin, Augusta Eustace A. Allen, Atlanta
William Harbin, Rome David Henry Poer, Atlanta

Awards

Ted F. Leigh, Atlanta, Chairman
Hoke Wammoth, Augusta Mark S. Dougherty, Atlanta
Charles H. Wasden, Macon

Industrial Health

Duncan Shepard, Atlanta, Chairman
John G. Sharpley, Savannah W. Bruce Schaefer, Toccoa
Robert M. Harbin, Jr., Rome Allen M. Collinsworth, Atlanta
Charles L. Ridley, Jr., Macon Alfred M. Battey, Augusta
George R. Conner, Columbus

Public Relations

Chris J. McLoughlin, Atlanta, Chairman
Peter L. Scardino, Savannah Robert G. Ellison, Augusta
Thomas L. Ross, Jr., Macon Eugene L. Ward, Gainesville
J. Lamont Henry, Atlanta W. C. Cook, Columbus
Stephen D. Smith, Rome Geo. R. Dillinger, Thomasville

Cancer

J. E. Scarborough, Atlanta, Chairman
Hoke Wammoth, Augusta Everett L. Bishop, Atlanta
David Henry Poer, Atlanta Thomas Harrold, Macon
R. C. Pendergrass, Americus Lee Howard, Sr., Savannah
Enoch Callaway, LaGrange Neal F. Yeomans, Waycross
W. F. Jenkins, Columbus Kirk Shepard, Thomasville
John Funke, Atlanta Major F. Fowler, Atlanta
John L. Barner, Athens Wadley R. Glenn, Atlanta

SPECIAL COMMITTEES

(Appointed annually)

Medical Civil Preparedness

Edgar M. Dunstan, Atlanta, Chairman
C. A. Eberhart, Atlanta Perry P. Volpito, Augusta
T. J. Ferrell, Waycross J. S. Skobba, Atlanta
Lee H. Battle, Jr., Rome Charles E. Dowman, Atlanta

American Medical Education Foundation

John L. Chandler, Jr., Augusta, Chairman
Edgar Woody, Jr., Atlanta, Co-Chairman
Robert R. McKnight, Augusta C. H. Richardson, Jr., Macon
James S. Holder, LaGrange Sage Harper, Douglas
Ernest F. Wahl, Thomasville C. H. Watt, Jr., Thomasville

Blood Banks

Warren B. Matthews, Atlanta, Chairman
George Dowling, Atlanta D. F. Mullins, Jr., Augusta
Walter L. Shepard, Augusta F. H. Thompson, Albany
Lee Howard, Jr., Savannah John H. Venable, Atlanta
Mr. J. Y. Bowen, Griffin R. C. Williams, Atlanta

Abner Wellborn Calhoun Lectureship

Glenville Giddings, Atlanta, Chairman
Charles L. Prince, Savannah L. M. Freedman, Savannah
Henry H. Tift, Macon

RELATED COMMITTEES

Medical Advisory to Selective Service

William G. Hamm, Atlanta, Chairman
David Henry Poer, Atlanta, Co-chairman
Carter Smith, Atlanta S. A. Garrett, D.D.S., Atlanta
T. F. Sellers, Atlanta Chas. C. Rife, D.V.M., Atlanta
L. Minor Blackford, Atlanta Homer E. Nash, Atlanta
Cyrus W. Strickler, Jr., Atlanta Dana Hudson, R.N., Atlanta
A. O. Linch, Atlanta

First District Advisory Subcommittee

J. C. Metts, Savannah, Chm. Albert M. Deal, Statesboro
William H. Fulmer, Savannah Cleveland Thompson, Jr.,
Oscar H. Lott, Savannah Waynesboro
David B. Fillingim, Savannah A. G. Pinkston, Jr., Glennville

F. G. Eldridge, Valdosta
Lester Harbin, Rome

John T. Mauldin, Atlanta

Rural Health

George T. Nicholson, Cornelia, Chairman
T. F. Sellers, Ex-Officio, Atlanta
1—Charles T. Brown, Guyton 6—W. A. Dodd, Wrightsville
2—W. B. Stoner, Sylvester 7—D. M. Cornett, LaFayette
3—M. F. Arnold, Hawkinsville 8—Hubert Milford, Hartwell
4—T. A. Sappington, Thos'ton 9—Joe J. Arrendale, Cornelia
5—James M. Combs, Atlanta 10—C. A. Wilson, Brunswick

Insurance Board

David R. Thomas, Jr., Augusta, Chairman
Charles S. Jones, Atlanta, Co-Chairman
W. L. Pomeroy, Waycross Luther H. Wolff, Columbus
D. Lloyd Wood, Dalton John L. Elliott, Savannah
Harry D. Pinson, Augusta Herbert M. Olnick, Macon

Veterans' Affairs

Hartwell Joiner, Gainesville, Chairman
A. R. Bush, Dublin Herbert S. Alden, Atlanta
A. O. Colquitt, Jr., Marietta C. C. Butler, Columbus
Bernard P. Wolff, Atlanta L. M. Freedman, Savannah
Charles R. Andrews, Canton Winston E. Burdine, Atlanta

Hospitals

R. F. Spanjer, Cedartown, Chairman
H. Ansley Seaman, Waycross H. E. Weems, Perry
A. J. Davis, Augusta L. C. Yeargin, Dalton
H. A. Goodwin, Summerville W. B. Fackler, Jr., LaGrange
W. D. Hazlehurst, Macon Herbert D. Tyler, Thomaston
R. C. Williams, Atlanta, Rufus F. Payne, Augusta
Ex-Officio Robert Martin, III, Cuthbert
Ernest Thompson, Monroe

Chronic Illness

L. Minor Blackford, Atlanta, Chairman
E. F. Wahl, Thomasville A. Calhoun Witham, Augusta
Simone Brocato, Columbus J. B. Neighbors, Jr., Athens

Crawford W. Long Memorial

Lester Rumble, Jr., Atlanta, Chairman
Perry P. Volpito, Augusta A. B. Boyd, Athens

Mental Health

Rives Chalmers, Atlanta, Chairman
J. R. Shannon Mays, Macon P. T. Scoggins, Commerce
Paul L. Schroeder, Atlanta Albert J. Kelley, Savannah
George H. Alexander, Forsyth T. J. VanSant, Jr., Marietta
Arthur M. Knight, Jr., Waycross Carl A. Whitaker, Atlanta

Crippled Children

J. C. Hughston, Columbus, Chairman
Ruth M. Waring, Savannah James W. Bennett, Augusta
F. James Funk, Jr., Atlanta Harold W. Muecke, Waycross
John L. Chandler, Jr., Augusta

Bon M. Durham, Americus
R. C. Pendergrass, Americus
L. C. Cheves, Montezuma
John E. Smith, Fitzgerald

Peter Graffagnino, Columbus
Luther H. Wolff, Columbus
Roy L. Gibson, Columbus

A. G. Little, Jr., Valdosta
B. G. Owens, Valdosta
H. L. Moore, Brunswick
Sage Harper, Douglas

J. B. Brown, Jr., Baxley
J. W. Yeomans, Jesup
Jesse L. Parrott, Hahira

Fourth District Advisory Subcommittee

J. W. Chambers, LaGrange, *Chairman*
George P. Kinnard, Newnan
J. H. Arnold, Newnan
K. D. Grace, LaGrange
J. S. Holder, LaGrange

Douglas L. Head, Jr., Zebulon
H. C. King, Griffin
William R. King, Jr., Griffin
V. B. Williams, Griffin
James A. Johnson, Jr.,
Manchester

Fifth District Advisory Subcommittee

Robert W. Candler, Atlanta, *Chairman*
Joseph C. Massee, Atlanta
Edgar M. Dunstan, Atlanta
Sterling H. Jernigan, Atlanta
H. H. Allen, Decatur

Charles E. Dowman, Atlanta
Linton H. Bishop, Jr., Atlanta
Edgar Boling, Atlanta
T. E. McGeachy, Decatur
William K. Kerr, Chamblee

Sixth District Advisory Subcommittee

John A. Bell, Jr., Dublin, *Chairman*
E. Y. Walker, Milledgeville
O. C. Woods, Milledgeville
M. W. Hurt, Sandersville
J. R. S. Mays, Macon

Frank Vinson, Fort Valley
Fred J. Coleman, Dublin
J. P. Woodhall, Macon
W. K. Jordan, Macon
Henry H. Tift, Macon

Seventh District Advisory Subcommittee

John M. McGehee, Cedartown, *Chairman*
Roy Pope, Jr., Chickamauga
T. A. Cochran, Ringgold
D. L. Wood, Dalton
Charles M. Garland, Jr., Smyrna

Lester Harbin, Rome
John McCall, Rome
Wm. B. Quillian, Cartersville
Alfred O. Colquitt, Jr.,
Marietta
L. R. Lang, Calhoun

Eighth District Advisory Subcommittee

T. J. Ferrell, Waycross, *Chm.* S. T. Parkerson, McRae

Ninth District Advisory Subcommittee

Alex B. Russell, Winder, *Chm.*
O. C. Pittman, Commerce
John M. Hulsey, Jr.,
Gainesville
Edward W. Grove, Gainesville
Robert T. Jones, III, Canton

Chas. R. Andrews, Jr., Canton
Joe J. Arrendale, Cornelia
W. Bruce Schaefer, Toccoa
W. Ben Nalley, Helen
C. J. Roper, Jasper

Tenth District Advisory Subcommittee

M. C. Adair, Washington, *Chairman*
John B. O'Neal, III, Elberton
H. L. Cheves, Union Point
A. S. Johnson, Sr., Elberton

M. A. Hubert, Athens
H. T. Kennedy, Warrenton
Albert G. LeRoy, Thomson
Lynn M. Huie, Monroe
J. H. Nicholson, Madison

Augusta Advisory Subcommittee

C. G. Henry, Augusta, *Chairman*
John H. Sherman, Augusta
C. M. Mulherin, Augusta

W. K. Philpot, Augusta
G. L. Kelly, Augusta

Columbus Advisory Subcommittee

Luther H. Wolff, Columbus, *Chairman*
Roy Gibson, Columbus
Peter C. Graffagnino, Columbus

Polk Land, Columbus
S. A. Roddenbery, Columbus

Macon Advisory Subcommittee

Willard R. Golsan, Macon, *Chairman*
Charles N. Wasden, Macon
John I. Hall, Macon

Harold C. Atkinson, Macon
Thomas L. Ross, Jr., Macon

Savannah Advisory Subcommittee

L. B. Dunn, Savannah, *Chairman*
T. A. McGoldrick, Savannah
J. C. Metts, Savannah

W. L. Osteen, Savannah
Jacob Rubin, Savannah

STATE BOARDS

State Board of Medical Examiners

(Meets in June and October)

Charles K. Wall, Thomasville, President—1955
Albert M. Deal, Statesboro, President-Elect—1955
Grady N. Coker, Canton—1956
Fred J. Coleman, Dublin—1956
Glenville Giddings, Atlanta—1957
Q. A. Mulkey, Millen—1957
R. H. McDonald, Newnan—1958
J. W. Palmer, Ailey—1958
Alex B. Russell, Winder—1958
L. N. Willis, Bainbridge—1959

State Board of Health

(Meets in April and October)

R. Lee Rogers, Gainesville, Chairman (9th District)—1956
J. M. Byne Jr., Waynesboro, Vice Chairman (1st District)—
1957
A. G. Funderburk, Moultrie (2nd District)—1957
O. C. Brannen, Columbus (3rd District)—1960
M. M. Head, Zebulon (4th District)—1955
Harold P. McDonald, Atlanta (5th District)—1960
A. M. Phillips, Macon (6th District)—1956
Fred H. Simonton, Chickamauga (7th District)—1956
C. J. Maloy, McRae (8th District)—1956
Thomas W. Goodwin, Augusta (10th District)—1955

Georgia Dental Association Representatives

J. M. Hawley, Columbus—1958
J. G. Williams, Atlanta—1958

Georgia Pharmaceutical Association Representatives

J. B. Butts, Milledgeville—1959
W. W. Webb, Leslie—1959

State Medical Education Board

(Meets in June and October)

John W. Mauldin, Alma, Chairman—1957
J. Hubert Milford, Hartwell, Vice-Chairman—1957

C. L. Howard, Pelham—1957
Peter B. Wright, Augusta—1954-56
H. Dawson Allen, Jr., Milledgeville—1955-57

Medical Examiners

State Board of Workmen's Compensation

Albert A. Rayle, Atlanta
Jack C. Norris, Atlanta
F. Kells Boland Jr., Atlanta
Marcus Mashburn Sr., Cumming
Hugh Hailey, Atlanta

Hospital Advisory Council

(Meets in April and October)

Representatives from Georgia Hospital Association

Mr. Oscar Hilliard, Fort Oglethorpe, Chairman—1956
Mr. Arthur T. Stewart, Greensboro—1955
Mr. George E. Linney, Americus—1957

Representatives, Medical Association of Georgia

H. Dawson Allen, Milledgeville—1956
J. T. McCall, Rome—1956
J. K. Quattlebaum, Savannah—1957
Joseph C. Read, Atlanta—1957
R. F. Spanjer, Cedartown—1955

Representative from the Georgia Dental Association

Thomas Conner, Atlanta—1957

Representative, Georgia Nursing Association

Miss Dana Hudson, Atlanta—1957

Representatives, State at Large

Mr. Walter Graefe, Griffin—1957
Mr. J. J. McLanahan, Elberton—1957
Mr. Frank A. Smith, Clayton—1956
H. C. Derrick, Lafayette—1959
Mr. H. Carson Smith, Lawrenceville—1959

Ex-Officio Members

T. F. Sellers, Director, State Health Department
Mr. Eugene Cook, Attorney General
Mr. Alan Kemper, Director, State Welfare Dept.
Mr. B. E. Thrasher, State Auditor

Constitution and By-Laws

of the

Medical Association of Georgia

As revised by the House of Delegates at the 105th Annual Session May 3, 1955.

(Supercedes Any MAG Constitution and By-Laws Prior to May 3, 1955)

CONSTITUTION

ARTICLE I.

Name of the Association

The name of this organization is *The Medical Association of Georgia*.

ARTICLE II.

Purposes of the Association

The purposes of the Association shall be to advance the science of medicine; to promote the interests and uphold the honor of the profession of medicine; to acquire, utilize and disseminate information relative to all diseases and degenerative processes affecting mankind to the end that the people of Georgia may have the most adequate medical care possible; to promote public health, and to foster cordial relations between the members of the medical profession and the general public.

ARTICLE III.

Component Societies

Component societies are those county medical societies which hold charters from the Association or which may hereafter be organized and chartered by the House of Delegates of the Association.

ARTICLE IV.

Composition of the Association

Sec. 1. The Association is composed of members and delegates.

Sec. 2. Members. The members of the Association are the members of the component county medical societies.

Sec. 3. Delegates. Delegates are those members elected in accordance with this Constitution and By-Laws to represent their component county medical societies in the House of Delegates of the Association.

ARTICLE V.

House of Delegates

Sec. 1. Powers. The legislative body of the Association is the House of Delegates and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.

Sec. 2. Composition. The House of Delegates is composed of (1) delegates elected by the component county medical societies, (2) the officers and past presidents of the Association and (3) the delegates to the American Medical Association.

ARTICLE VI.

Council

Sec. 1. The Council shall be the Board of Trustees and the Board of Censors of the Association. It shall carry out the mandates and policies as determined by the House of Delegates. The Council shall have full authority and power of the House of Delegates between sessions of that body. The Council shall have charge of all the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

Sec. 2. The Council shall consist of the President, President-Elect, the Immediate Past-President, the Secretary-Treasurer, and one Councilor from each Congressional District in the State of Georgia.

ARTICLE VII.

Sessions and Meetings

Sec. 1. Annual Session. The Association shall hold an annual session during which there shall be general meetings open to all registered members, delegates and guests.

Sec. 2. Time and Place. The time and place for holding each annual session shall be fixed by the Council.

Sec. 3. Special Meetings. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Council, twenty delegates or upon written petition of one-fourth of the members of the Association.

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts, which shall be coextensive with the Congressional Districts in Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies.

ARTICLE IX.

Officers

Sec. 1. Officers. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, Secretary-Treasurer, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, and one Councilor and a Vice-Councilor from each of the Councilor Districts.

Sec. 2. Election and Eligibility. The officers of the Association shall be elected by the members during the annual session. No person shall be eligible to an elective office who has not been a member of the Association for the preceding three years.

Sec. 3. Terms of Officers. The President-Elect shall be elected annually. He shall become President on his installation at the close of the next annual session. If the President-Elect be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session. Other officers shall be elected for terms of one year each, except the Secretary-Treasurer, the Councilors and Vice-Councilors, who shall serve for three years. One-third, or as near as may be, of the Councilors and Vice-Councilors shall be elected annually.

ARTICLE X.

Funds and Expenses

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component county medical society. The amount of the assessment shall be set annually by the House of Delegates upon the recommendation of the Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates.

The Council shall submit an annual budget for the next succeeding fiscal year to the House of Delegates. This budget shall not exceed the anticipated current income for the period covered by it. The Council shall manage the finances of the Association and shall supervise all funds, investments and expenditures of the Association. All resolutions providing for appropriations, recommended by the Council, shall be included in the annual budget, subject to final approval of the House of Delegates.

ARTICLE XI.

Official Publication

The official publication of the Association shall be the *Journal of the Medical Association of Georgia*, in which shall be published all official Association notices, abstracts of transactions of the House of Delegates and general meetings of the Association, the annual budget, complete financial report as directed by Council, and abstracts of meetings of Council.

ARTICLE XII.

Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII.

Amendments

The House of Delegates may amend this Constitution by a two-thirds vote of the Delegates present at any annual session, provided that such amendment shall have been presented to the House of Delegates at the previous annual session and that it shall have been published during the year in *The Journal of the Association*, or sent officially to each component county society at least two months before the annual session at which final action is to be taken.

BY-LAWS

CHAPTER 1.

Membership

Sec. 1. Any physician holding the degree of Doctor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been adjudged guilty of moral turpitude or other serious crime, may be eligible for membership in a component society of the Association.

Sec. 2. The name of a physician recorded on the official roster of a component county society, who has paid the annual dues and assessments of the component county society and of the Association, shall be prima facie evidence of membership in the Association.

Sec. 3. Membership in the Association shall be classified as active, associate, honorary, life and scientific.

Sec. 4. Active Members. All members shall be active, including the right to vote and hold office, unless otherwise classified by action of the component county society.

Sec. 5. Associate Members. Any physician who is not engaged in the regular practice of medicine for any one of the following reasons, namely: (1) during organized periods of hospital training and graduate education, (2) during periods of service in the Armed Forces, (3) after retirement or (4) for whom the payment of dues would constitute a hardship, may be classified by the component county society as an associate member. Associate Members shall be entitled to all the rights and privileges of the Association except that they shall not pay dues or receive *The Journal* without subscription thereto.

Sec. 6. Honorary Members. Eminent physicians and other persons who have distinguished themselves in the science of medicine, or for contributions to human welfare, may be elected to Honorary Membership in the Association by the House of Delegates upon nomination by any component county society and approval of the Committee on Professional Conduct of the Medical Association of Georgia. Such Honorary Members may be issued an appropriate certificate of membership without payment of dues.

Sec. 7. Life Members. A Life Membership may be granted by the House of Delegates, upon the recommendation of the component county society, to any physician who has had not less than forty years of active membership in the Association or has passed his seventieth birthday. He shall not be subject to payment of dues.

Sec. 8. Scientific Members. There shall be created a new division of membership to be known as Scientific Membership. The privileges of membership under this classification shall entitle the holder thereof to all phases of the Association's activities pertaining to the study of scientific medicine, and shall include

the right to attend all scientific meetings, postgraduate study courses, and scientific sessions of component organizations. Scientific members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to Medical Defense or to receive *The Journal* except by regular subscription.

Sec. 9. A physician who is under sentence of expulsion from a component county society, or whose name has been dropped from its roll of members, shall not be entitled to any of the rights, privileges or benefits of the Association, nor shall he be permitted to take part in any of its proceedings.

Sec. 10. The cause of the failure of a practicing physician to affiliate himself with an available component county society, at any time, shall be ascertained before election to membership.

Sec. 11. Eligible physician members of the State and Federal medical services and full time members of approved medical faculties not engaged in private practice of medicine shall pay half the annual dues of the Association provided similar action has been taken by the component county society.

CHAPTER II.

General Meetings

Sec. 1. The general meetings shall be open to all members and guests who have complied with the registration requirements. These meetings shall be presided over by the President or a Vice-President.

Sec. 2. The program for the general meetings shall be prepared by the Committee on Scientific Work and approved by the executive committee of the Council at least 60 days before the Annual Session of the Association and published in the issue of *The Journal* preceding the Annual Session.

Sec. 3. All papers read before the meetings shall become the property of the Association, and shall be deposited with the Secretary-Treasurer immediately after being read. Failure to comply with this and other rules set forth by the Committee on Scientific Work regarding papers, discussions and exhibits shall automatically bar scheduled participation in the scientific sessions in the future from this member for a period of not less than five years unless he presents an acceptable excuse.

Sec. 4. Upon invitation of the President any physician may register at a general meeting of the Association as a guest upon presentation of adequate evidence of membership in good standing in a component unit of the American Medical Association.

Distinguished lay persons and physicians may be invited as special guests of the Association by the President or by action of the Council. Privileges of the floor may be extended to guests at the discretion of the presiding officer.

CHAPTER III.

House of Delegates

Sec. 1. The House of Delegates shall meet on the first and last day of the annual session at a time fixed by the Council and at such other times as may be necessary for the transaction of the business of the Association.

Sec. 2. Each component county society shall elect one delegate and a corresponding alternate for each twenty-five members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. It shall be the duty of the President to have the representation of each component county society checked by the Committee on Credentials at the time of the annual session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy.

Sec. 3. Forty of the registered members of the House of Delegates shall constitute a quorum. All sessions of the House of Delegates shall be open to the members of the Association, except when in Executive Session.

Sec. 4. The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice-Speaker. In the absence of both, a delegate agreeable to it may preside.

Sec. 5. The Secretary-Treasurer of the Association shall be the Secretary of the House of Delegates or, in his absence, by a delegate appointed by the President. The Executive Secretary may serve in this capacity.

Sec. 6. The following shall be the general Order of Business at all meetings of the House of Delegates : 1. Call to order by the President; 2. Roll Call; 3. Election of Speaker and Speaker pro tem; 4. Reading and adoption of minutes; 5. Reports of officers; 6. Reports of Committees; 7. Unfinished business; 8. New business.

Sec. 7. For the purpose of expediting proceedings the President shall appoint from the members of the House of Delegates the Reference Committees and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in the debate, but shall not have the right to vote.

Sec. 8. All reports and resolutions shall be referred to the appropriate Reference Committees before action is taken by the House of Delegates.

Sec. 9. The House of Delegates shall nominate members of all Boards required by the Laws of Georgia.

CHAPTER IV.

Council

Sec. 1. The Council shall meet on the last day of the annual session of the Association to organize and at intervals of not more than four months apart until the next annual session. Special meetings of the Council may be held on the call of the President or upon request of three members of the Council.

Sec. 2. The Council shall be composed of the President, the President-Elect, Vice-Presidents, Secretary-Treasurer, and one Councilor or Vice-Councilor from each Councilor district. Each Councilor and Vice-Councilor shall be nominated by each district society at the time of its annual meeting. In the event of a vacancy in the office of a Councilor and Vice-Councilor, the vacancy may be filled temporarily by appointment by the President from members of that district society.

Sec. 3. The Council shall set up an Executive Committee composed of the President, Secretary-Treasurer, Chairman of the Council and two other members of the Council. The President shall be the chairman of the Executive Committee. It shall meet not less often than bi-monthly to review the affairs of the Association. The Committee shall make recommendations to the Council and shall carry out such items of business as are referred to it by the Council.

Sec. 4. The Chairman of the Council shall be elected annually at the organization meeting and shall serve one year, or until his successor is elected. He shall preside over its meetings and appoint all necessary committees. A Vice-Chairman shall be elected from among its members. The Secretary-Treasurer of the Association shall be the Secretary of the Council.

Sec. 5. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws.

Sec. 6. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to the Association. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

Sec. 7. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and

to aid in, the betterment of the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

Sec. 8. Charters for county and district societies shall be issued on approval of the Council and shall be signed by the President and Secretary-Treasurer of the Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Sec. 9. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all the rights and privileges provided for component societies until such counties shall be organized separately. A physician residing in a county not having a component society shall be referred to an adjacent component county society by the Council for consideration for membership. Choice of any other component county society by such a physician for membership shall be made only with the full consent of all component societies involved.

Sec. 10. The Council shall provide for and superintend the issuance of all necessary publications of the Association, including proceedings, transactions and memoirs.

Sec. 11. The Chairman of the Council shall appoint from among its members, a committee of three members to be known as the Committee on Auditing and Appropriations, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each annual session. This proposed budget shall be prepared by the Committee on Auditing and Appropriations for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval after which it becomes effective. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Sec. 12. The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the annual session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it for the good of the Association without restriction.

Sec. 13. The Council shall appoint, at least six months before the annual session, a committee, consisting of three or more of its members, to be known as the Committee on Arrangements for the annual session. This committee shall appoint a general chairman of a local committee on arrangements, who shall be a member of the component society in which the annual session is to be held. This local Chairman shall appoint, from the members of his county society, the personnel of the local committee on arrangements. The local committee on arrangements shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements for the annual session. All expenditures made by that committee in connection with the annual session must be authorized in advance by the Committee on Auditing and Appropriations of the Council. Immediately after the annual session the Committee on Arrangements of the Council shall forward to the Secretary-Treasurer any accumulated balance. Auditing and Appropriations.

Sec. 14. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between annual sessions of the Association. The appointee shall serve until his successor has been elected and installed.

Sec. 15. The Council may appoint an Assistant Secretary-Treasurer or an Executive Secretary—either or both and fix their terms of employment.

Sec. 16. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association subject to approval of the House of Delegates.

Sec. 17. The Council shall provide such headquarters for the Association as may be required to conduct its affairs.

Sec. 18. The Council shall have control of all technical exhibits at the annual sessions.

Sec. 19. The Council shall fix the bond of the Secretary-Treasurer and all other necessary personnel of the Association.

Sec. 20. The Council shall have full and complete charge of all public relations of the Association, subject only to the House of Delegates.

CHAPTER V.

Election of Officers

Sec. 1. The President-Elect, Vice-Presidents, Secretary-Treasurer, Councilors and Vice-Councilors shall be elected by ballot by the members of the Association. Nominations for these officers except Councilors and Vice-Councilors shall be made orally as the last order of business at the first meeting on the first day of the scientific session. No nominating or seconding speech shall exceed two minutes. The President shall appoint a Committee of not less than three Tellers immediately after the close of nominations who shall have charge of the election.

Sec. 2. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations for Councilor and Vice-Councilor from such district shall be made from the floor. One third of the Councilors and Vice-Councilors shall be elected annually.

Sec. 3. The Secretary-Treasurer shall have prepared in advance an official ballot. One ballot shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in a locked ballot box provided by the Secretary-Treasurer and kept in the custody of the Tellers designated by the President. The key shall be kept by the Chairman of the Tellers.

Sec. 4. Voting shall take place during the hours of the scientific program up to 10:30 a. m. of the last day of the annual session. At that time the Committee of Tellers appointed by the President shall count the ballots and report their findings to the members at the last meeting of the Association. The candidate for President-Elect receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select the President-Elect from the two candidates having the highest number of votes by secret ballot. Other officers shall be elected by receiving the highest number of votes on the first ballot.

Sec. 5. Delegates and Alternates to the American Medical Association shall be elected in the same manner and at the same time and in accordance with the Constitution and By-Laws of the American Medical Association.

CHAPTER VI.

Duties of Officers

Sec. 1. The President. The President shall preside at the organization meeting of the House of Delegates and at all meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an address at such time during the annual session as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession and of the Association in the State during his term of office. So far as practicable he shall visit by appointment the various district societies, and shall assist the Councilors in building up the county societies, and in increasing the prestige of the Association. He shall be a member of the Council and its Executive Committee, and shall be a member of all committees of the Association with the authority to call a meeting of any Committee when necessity demands it or after failure of the chairman to do so. With the

consent of the Council he shall terminate any committee whose function has been fulfilled. It shall be his duty with the approval of the Council, to replace any member of any committee who fails to show interest in performing the duties assigned to him.

Sec. 2. The President-Elect. The President-Elect shall be a member of the Council, and shall be a member ex-officio of all standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and the Standing Committees.

Sec. 3. The Vice-Presidents. The Vice-Presidents shall assist the President in the discharge of his duties. Upon request or in the absence of the President, the Vice-Presidents will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice-Presidents, in their order shall succeed him for the unexpired term.

Sec. 4. The Secretary-Treasurer. (a) The Secretary-Treasurer or his representative shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and its Executive Committee and an ex-officio member of all committees.

Sec. 4. (b) He shall be custodian of all record books and papers belonging to the Association and shall keep account of all funds of the Association which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall supply all component societies with the necessary blanks for making their annual reports, and shall collect the regular per capita assessments from the component societies. The amount of his salary shall be fixed by the Council.

Sec. 4. (c) He shall give bond in the amount of a sum to be fixed by the Council. He shall receive all funds of the Association, together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at the last meeting of the fiscal year at the annual session of the Association. This shall consist of an itemized statement of all financial transactions of the past year, all accounts made, money received and disbursed with vouchers attached. The fiscal year includes the period of time between January 1st and December 31st. This financial report shall be published in The Journal as soon as practicable after the end of each fiscal year.

CHAPTER VII.

Component County Societies and District Societies

Sec. 1. County and District Societies. All county and district societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state which have adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitution and by-laws shall have been submitted to the Council and received its approval. A component society shall consist of three or more active members.

Sec. 2. Charter. Upon application to and recommendation by the Council, the House of Delegates shall provide and issue charters to county and district medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary-Treasurer. The House of Delegates shall have authority to revoke the charter of any component county society or district society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws. Only one component county society shall be chartered in each county.

Sec. 3. *Names of Societies.* The name and title of each component county society and district society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of The Medical Association of Georgia.

Sec. 4. *Custody of Charter.* The charter of each component county society and district society as issued by The Medical Association of Georgia, shall be preserved and shall be in the custody of the secretary of such society at all times.

Sec. 5. *Constitutions and By-Laws.* Each component county society and district society shall have a constitution and by-laws. These shall be in conformity with the Constitution and By-Laws of The Medical Association of Georgia, and a copy thereof shall be transmitted to the headquarters of The Medical Association of Georgia for approval and record.

Sec. 6. *Purposes and Duties.* Each component county society shall have general direction of the affairs of the profession in the county and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

Sec. 7. *Official Records.* The official copy of the constitution and by-laws of each component county society shall be kept in a special book provided for that purpose. In it shall be entered all amendments which have been notified by the Council of The Medical Association of Georgia. It shall contain the signature of each member who is entitled to membership in The Medical Association of Georgia, together with the date of his election, decease, resignation or expulsion. It shall be the duty of the secretary to preserve this book and hold it available when required for reference.

Sec. 8. *Delegates and Alternates.* Each component county society at its annual meeting shall elect delegates and alternates to represent it in the House of Delegates of the Association in accordance with these By-Laws, unless other definite procedure for the selection of delegates is provided in its constitution and by-laws. The secretary of each component county society shall send a list of such delegates to the Secretary-Treasurer of the Association at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with these provisions. In the absence of, or the disability or disqualification of a delegate, the vacancy shall be filled by the President from other members of the same component county society.

Sec. 9. *Combined Counties.* The House of Delegates shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district or other classes of societies. Such societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for component county societies.

Sec. 10. *Annual Meeting.* Each component county society shall designate the meeting held nearest to January 1st of each year as its annual meeting, at which time delegates to the House of Delegates, and a local member of the sub-committee on Legislation and sub-committee on Public Health will be chosen, and their names forwarded promptly to the Secretary of the Association.

Sec. 11. *Purposes and Duties of District Societies.* District Societies shall have one or more meetings during the year. A Councilor and a Vice-Councilor shall be nominated at the appropriate annual meeting and forwarded to the Secretary of the Association to be elected by the Association for terms of three years in a rotating manner with other district societies. At the same time, each shall elect a member to the sub-committees on Legislation and Public Health of the Association.

CHAPTER VIII.

Dues and Assessments

Sec. 1. The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component

county society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the Secretary-Treasurer of the Association. Neither shall the Secretary-Treasurer of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.

An active member who fails to pay dues for one or more years current year plus one year's dues in arrears subject to reapplication and approval by his county society.

Sec. 2. The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

Sec. 3. For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

Sec. 4. Any county society which fails to make the reports required before the annual session of the Association, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

CHAPTER IX.

Standing Committees

Sec. 1. The Standing Committees of the Association shall be as follows:

- (A) Committee on Scientific Work
- (B) Committee on Legislation
- (C) Committee on Medical Education
- (D) Committee on Medical Defense
- (E) Committee on Professional Conduct
- (F) Committee on History and Vital Statistics
- (G) Committee on Public Health
- (H) Committee on Maternal and Infant Welfare
- (I) Committee on Rural Health
- (J) Committee on Industrial Health
- (K) Committee on Public Relations
- (L) Committee on Cancer
- (M) Committee on Insurance
- (N) Committee on Veterans Affairs
- (O) Committee on Constitution & By-Laws
- (P) Committee on Awards
- (Q) Committee on Woman's Auxiliary
- (R) Committee on Hospitals

Sec. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. One member of each standing committee shall be appointed each year by the President to serve for three or more years as required by each committee and announced at the time of the final meeting of the Association each year. Provided that for the first year the President shall appoint three or more members as required with one member to serve for the necessary graduated period of years to meet these requirements. Failure of a member to carry out the duties of his committee assignment during any year shall automatically cause his removal at the time of the annual session and the President, with the consent of the Council, shall appoint another member to fill his unexpired term. All committees shall make an annual report in writing to the Association headquarters office sixty days in advance of the Annual Session.

(A) The Committee on Scientific Work. The Committee on Scientific Work shall be composed of five members: the President, the Secretary-Treasurer and three members appointed for terms of three years each. The senior appointed member shall

serve as chairman. The duties of the Committee on Scientific Work shall be to prepare and publish the Scientific Program of the annual session, subject to the approval of Council. It shall also prepare and publish all rules and regulations governing the selection and presentation of papers, discussions and Scientific Exhibits before the general meetings and shall present them for publication in *The Journal of the Association*.

The presentation of Scientific Exhibits for the annual session shall be under the direction of this committee. For this purpose, the committee may set up a sub-committee of three or more members with representatives from the two medical schools of the State.

All lectureships of the Association shall be under the control of this committee, but special sub-committees may be established to advise the committee concerning the selection of proper speakers for each lectureship. These special lectures shall be given before the general meetings at a time selected by the Committee on Scientific Work.

(B) The Committee on Legislation. The duties of the Committee on Legislation shall be to represent the Association in securing and enforcing legislation in the interests of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local and national affairs. It shall further the education of the general public in health matters fostering a sane point of view about proper medical care.

Each component county society and district society shall designate one member at its annual meeting to serve with the Committee on Legislation in an active capacity. Vacancies in this special sub-committee shall be filled by the President. In addition, the Woman's Auxiliary shall be requested to form a similar committee with representatives from each component auxiliary. The President may appoint for one year an Advisory Committee of any number he deems advisable.

(C) The Committee on Medical Education shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies whenever possible and serve for the Council on Medical Education of the American Medical Association in this state. All problems relating to the postgraduate study of medicine shall be referred to this committee.

(D) The Committee on Medical Defense. The Committee on Medical Defense shall consist of five members, of whom the Chairman of the Council and the Secretary-Treasurer shall be members. The other members, one of whom shall be elected Chairman, shall be elected by the Council for terms of five years each. The duties of this committee shall be to investigate and defend all damage suits brought against the Medical Association of Georgia; to investigate all claims of alleged malpractice made against its members and to take full charge of such cases that are deemed to be worthy of defense; to defend all such cases in the courts of last resort, to furnish General Counsel and pay court costs usual to such litigation, and reasonable fees for local attorneys as shall be arranged by Council. Any member who has indemnity insurance shall have such insurance bear its portion of the expense. However, they shall not pay, or obligate The Medical Association of Georgia to pay any judgment rendered against any member upon the final determination of any case. It shall be empowered to contract with such agents and attorneys as it may deem necessary for the proper carrying out of this By-Law. The assistance for defense, as herein provided shall be available only to members of The Medical Association of Georgia in good standing.

Any member of the Association threatened with suit for alleged civil malpractice shall immediately communicate with the Secretary-Treasurer of the Association and shall give full and complete information in reference to all the circumstances alleged in the complaint. He shall immediately notify the Chairman of this committee who shall investigate the circumstances reported and shall advise with the attorneys or agents employed by the committee for this purpose. The member sued, or threatened with suit, shall be consulted and shall have the complete confidence of the committee in all transactions connected with the investigation in question. The committee shall have the authority to require of a constituent society or the president thereof, the appointment of a committee of investigation in any

such case, and it may direct the committee so appointed to report to the Committee on Medical Defense and not to the society from which it was appointed.

The Committee on Medical Defense may assist in the prosecution of illegal practitioners in the State of Georgia and assist in the enforcement of the Medical Practice Act of this State.

(E) The Committee on Professional Conduct. The Committee on Professional Conduct shall consist of the five most recent past presidents of the Association. The senior member shall be Chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of The Medical Association of Georgia. All complaints or accusations against any member of The Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigations of a member, shall become the concern of this Committee. Complaints may be made by an individual patient, physician, board of censors of any local medical society, attorney, or any officer of a regularly constituted court of law. Upon receipt of notice of such complaint, the Committee, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if the Committee is convinced that there is sufficient justification for a hearing the physician shall be requested to appear before at least three members of said Committee to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged only at such hearing. No member of this Committee shall sit in a hearing involving a physician from his Councilor District.

After deliberation, the Committee shall have a choice of one of the four following dispositions:

1. Dismiss the case because of insufficient grounds for a legitimate complaint.
2. Attempt a satisfactory adjudication of the complaint.
3. Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.
4. Refer to the Council of The Medical Association of Georgia all cases in which action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of The Medical Association of Georgia.

Nothing in this By-Law shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

(F) The Committee on History and Vital Statistics. It shall be the duty of the Committee on History and Vital Statistics to stimulate and promote the preparation of suitable articles on the history of the Association and its members, and shall recommend their publication to *The Journal of the Association*. It shall prepare memorials for deceased members, and arrange for their publication. It shall also report to the House of Delegates all new and eligible physicians who were licensed in the State during the past year indicating those who have become members of the Association. The Editor of *The Journal* and the President of the State Board of Medical Examiners shall be ex-officio members of this committee.

(G) The Committee on Public Health. The Committee on Public Health shall be assisted by a sub-committee of one member elected by each county and district society of the state. Its duty shall be to advise with the Governor and other State officials, and with the Georgia State Board of Health and other related groups in regard to all matters concerning the health of the citizens of Georgia. It shall meet at the time of each session of the Georgia State Legislature with the Committee on Legislation to give assistance in carrying out its duties.

The President may appoint for one year an Advisory Committee of any number he deems advisable.

(H) The Committee on Maternal and Infant Welfare shall be composed of seven members, three of whom shall be general practitioners. It shall regularly review and analyze the causes of all maternal deaths occurring in the State. It shall investigate conditions affecting maternal care in Georgia and make recommendations concerning improvements thereof. It shall establish

a working liaison with the Georgia State Obstetrical and Gynecological Society and the Georgia Pediatric Society and shall consider the establishment of annual post-graduate regional courses in obstetrics throughout the State with the cooperation of the Committee on Medical Education and Hospitals.

(I) The Committee on Rural Health shall concern itself with improving medical service in the more sparsely settled areas in the State. It shall be composed of one member from each of the Councilor Districts comprising the Association, in addition to the Director of the State Department of Public Health who shall be a member *ex-officio*. It shall investigate and make recommendations as to locating and staffing health centers and shall cooperate with the Council on Rural Health of the American Medical Association. The Committee shall designate a member to represent the Medical Association of Georgia at national conferences on rural health.

(J) The Committee on Industrial Health shall be composed of five members. The committee shall confer with both labor and management in stressing the importance of preventive rather than curative medicine. It shall investigate and make recommendations concerning the initiation of programs designed to improve safe working conditions for employees and to solve other industrial health problems. It shall cooperate in all respects with the Council on Industrial Health of the American Medical Association.

(K) The Committee on Public Relations shall be appointed by the President. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.

(L) The Committee on Cancer shall consist of one representative from the Association, one from each of the State-Aid Cancer Clinics, and one each from the Medical Colleges in the State who shall serve not less than three years, and the President shall appoint the chairman from among the members having the longest service. The chairman shall submit a list of physicians' names representing these groups for appointment by the President. An Executive Committee of this committee consisting of not less than six members shall be appointed by the President upon recommendation of the chairman.

It shall be the duty of this committee to represent the members of the Association in dealing with all matters pertaining to cancer, and in particular, it shall advise with the Division of Cancer Control of the Department of Public Health.

(M) The Committee on Insurance or Insurance Board shall consist of not less than five members appointed for a period of five years in rotation by the President. The committee may elect one of its members to be chairman or request the President to designate a member as chairman. Members appointed during the first four years shall serve staggered terms as designated by the President.

The four geographical quadrants and the central industrial area shall have representation on this committee. Also the chairman may nominate five lay persons with known interest in the field of insurance for appointment by the President, who shall serve with the Board in an advisory capacity.

It shall be the duty of this committee to formulate and administer all policies and plans pertaining to insurance insofar as such concern members of the Association. In particular it shall sponsor and promote the Georgia Plan including provision for necessary expenses.

(N) The Committee on Veterans Affairs shall represent the Association in all matters pertaining to all veterans.

(O) The Committee on Constitution and By-Laws shall recommend to the House of Delegates any amendments which seem to be necessary or advisable. Proposed amendments shall be referred to this committee before action is taken by the House of Delegates.

(P) The Committee on Awards shall have complete charge of all awards made by the Association or in the name of the Association. The decisions of this Committee shall be final in reference to recipients.

(Q) The Committee on the Woman's Auxiliary shall cooperate with, advise and direct the Auxiliary in all matters concerning the Association.

(R) The Committee on Hospitals shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this State and shall, when indicated, confer with the State Department of Health, the Georgia Hospital Association and all related organizations and make recommendations to the Association.

CHAPTER X.

Special Committees

Special committees may be created at any time when the necessity arises. Their necessity must be approved by the Council and they shall be appointed by the President.

CHAPTER XI.

The Journal

Sec. 1. The Journal of the Medical Association of Georgia herein referred to as The Journal, shall be under the control and direction of the Council. It shall appoint an Editor, and an Editorial Board and make any other provisions for the publication of The Journal which in its judgment are necessary. Such appointee or appointees shall serve at the pleasure of the Council, which shall have full discretionary power to promulgate rules and regulations governing the publication of The Journal; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

Sec. 2. The Council may employ a Business Manager of The Journal and other personnel and fix the terms of such employment.

Sec. 3. All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in The Journal. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

CHAPTER XII.

Rules and Ethics

Sec. 1. The Principles of Ethics of the American Medical Association shall govern the members of this Association.

Sec. 2. The deliberations of the Association shall be conducted in accordance with parliamentary usage contained in the then current edition of Robert's "Rules of Order, Revised," unless contrary to this Constitution and By-Laws.

CHAPTER XIII.

Amendments

These By-Laws may be amended at any Annual Session by a majority vote of the House of Delegates after the amendment has lain on the table for one day.

CHAPTER XIV.

On the adoption of this Constitution and these By-Laws all rules and regulations in conflict herewith are hereby repealed, provided that all officers, delegates and committeemen now in office shall continue their incumbency until their successors are duly elected and installed or chosen as herein provided.

STANDING RULES

1. The Committee on Scientific Work shall prepare the program for all scientific meetings of the Association at all Annual Sessions. It may divide the scientific work into whatever number of sections that seem advisable for the particular Annual Session. It shall appoint temporary officers for all sections until such time as the sections apparently become permanent. As each section becomes established it shall elect its own officers to such rules and regulations as may be laid down by the Committee on Scientific Work. The program for all general meetings shall be prepared by the Committee itself. In its work the Committee shall be subject to the approval of the Council and, when necessary, to the House of Delegates.

2. The Executive Committee of the Council shall constitute the Publications Committee of The Journal.



abstracts by georgia authors

Barfield, William E., Medical College of Georgia, Augusta, Ga. "Vaginal Moniliasis and Its Treatment," *Sou. Med. J.* 48:349-35 (April) 1955.

The availability of specific therapeutic agents for vaginitis of varied etiology demands differential diagnosis for proper selection of an effective therapeutic agent. It is well recognized that the majority of vaginal infections are caused by yeast-like organisms or trichomonas vaginalis, or both. A discussion of the incidence of vaginitis due to monilia (*Candida*) albicans, including dietary, hormonal, and metabolic factors is presented. Readily available methods of differential diagnosis including an office technique for culture of monilia are discussed. This paper deals with results of treatment of monilial vaginitis with two new fungicidal preparations containing Propion Gel with M-11, and a benzothiazole derivative (Asterol Dihydrochloride, 2½%). Both preparations were satisfactory in over 80 per cent of the cases. A therapeutic regimen is suggested for immediate relief of symptoms, as well as for prophylaxis against recurrence of moniliasis. The author suggests that the method of therapy is equal in importance to the effectiveness of the therapeutic agent used. The case report of severe perigenital dermatitis of six weeks duration in an 11 year old child is presented, with the method of diagnosis by official culture of vaginal secretions. The response to specific therapy was immediate and satisfactory.

Ellison, Robert G., Lois T. Ellison, and William F. Hamilton, Medical College of Georgia, Augusta, Ga. "Analysis of Respiratory Acidosis During Anesthesia," *Ann. Surg.* 141:375-382 (March) 1955.

A study of respiratory acidosis was carried out on 31 thoracic and 13 non-thoracic patients. Repeated samples of arterial blood, taken from an indwelling needle in the brachial artery, were analyzed for CO₂ and O₂ content, oxygen saturation, arterial pO and pCO, pH and whole blood buffer base. CO₂ retention occurred in all cases. In the majority the maximal pCO₂ was 100 mm Hg, but in many cases a peak of 175-200 mm Hg was reached. Many cases reached a high level within a few minutes after induction of anesthesia. No significant difference occurred with syncurine and succinylcholine. However, whenever NaO was used the arterial pCO₂ was higher. There was no significant difference in the degree of acidosis in the non-chest and chest cases. A dramatic and significant decrease in arterial pCO₂ occurred at the end of anesthesia when extubation was carried out. On opening the pleura, a mean increase of 15 mm Hg in arterial pCO₂ occurred. By manual assistance to respiration arterial pCO₂ was decreased but was not brought down to normal levels. Arterial oxygen saturation was normal in all cases. An inverse relationship between alveolar ventilation and arterial pCO₂ was demonstrated. No complications attributable to respiratory acidosis occurred in these patients.

Rumble, Lester, Jr., St. Joseph's Infirmary, Atlanta, Ga. "Side Effects of Anesthesia (and Anesthetists)," *J. South Carolina M.A.*, 51:61-66 (March) 1955.

In this article an analogy was drawn between some very excellent recommendations made in an article written in 1852 and the advice given in present day writings on anesthesia: It is surprising how little the fundamental principles of anesthesia have changed. Seven rules, written at that time, would serve any modern day anesthetist well. In spite of this, we still have a rather alarming incidence of post-anesthetic complications.

An outline for a relatively new technique of anesthesia is given, including the incidence of complications and some "theses" as to the basic causes of these events. Many times, the cause lies with the anesthetist and not with the agents employed.

Alexander, Robert S., Ph.D., Medical College of Georgia, Augusta, Ga. "Venomotor Tone in Hemorrhage and Shock," *Circ. Research* 3:181-190 (March) 1955.

Employing the injection technic for determining venous distensibility, an index to venomotor tone has been developed by measuring the volumes of blood required to produce specified changes in venous pressure. Measurement of this index in hemorrhage and shock experiments on anesthetized dogs demonstrates

a marked venous constriction in compensation for hemorrhage, and oscillation in venomotor tone correlating with the vasomotor waves in arterial blood pressure encountered in hemorrhagic hypotension. In the hypotension of shock, a serious deficiency in venomotor compensation develops, which must result in pooling of blood in the venous system and contribute significantly to the circulatory failure.

Jourard, Sidney M. and Paul F. Secord, Emory University, Emory University, Ga. "Body-Cathexis and the Ideal Female Figure," *J. Abnormal & Social Psych.* 50:243-246 (March) 1955.

PROBLEM: To determine the relationships between cathexis-ratings for selected body-parts, and three expressions of the size of those parts: measured size, self-estimated size, and self-ratings of ideal size. Hypotheses: (a) Cathexis-ratings are correlated with measured and estimated size and with the magnitude of deviations between measured size and ideal size. (b) Self-ratings of ideal size, as a cultural stereotype, are much less variable than direct measures of size.

SUBJECTS: Sixty female college students, mean age 22.79 years, range 18-36, and SD 4.25.

PROCEDURE: Subjects signified their satisfaction-dissatisfaction on a seven-point Body-Cathexis scale concerning their *height, weight, bust, waist, hips, thighs, calves, ankles, feet, nose length, shoulder width, and neck length*. Each body aspect was directly measured, and size-estimates and self-ratings of ideal size obtained.

RESULTS: Significant correlations were obtained between cathexis-ratings and body measurements. The direction of seven of the *r*'s signified that small size was correlated with satisfaction, while for *bust*, large size seemed desirable. Desirability of small size was further supported by significant *t*-ratios for a comparison between mean measured size and mean ideal size. Deviation between measured and ideal size correlated still more highly with cathexis-ratings, suggesting the existence of personal ideals deviating somewhat from the cultural stereotype. Finally, SD's for ideal size-ratings were significantly smaller than SD's for measured size.

CONCLUSIONS: There appears to be a shared ideal for the size of the female figure. Female S's vary their cathexis-ratings for aspects of their bodies as they approach or deviate from their conception of this ideal.

Abbott, Osler A., Van Fleit, William E., and Roberto, Albert E., Emory University Hospital, Emory University, Ga. "Experiences with Extending the Indications for the Use of Tracheal and Bronchial Grafts," *J. Thoracic Surg.* 29:217-237 (March) 1955.

The authors review the literature on the methods used to replace defects in the wall of the trachea and bronchus produced either by disease, necessary surgical excision, or trauma. The most satisfactory method of replacement appears to be the use of autogenous dermal grafts supported by an internal skeleton of silver wire as described by Gebauer. Indications for consideration of the need of grafts are outlined and the experiences of the authors with their use reviewed. The successful use of two such grafts in childhood are reported, following the salvage of an entire right lung threatened by a benign stricture of the mainstem bronchus, and the salvage of both lungs threatened by a bronchogenic cyst of the posterior tracheal wall. The use of such grafts to reconstruct the left mainstem bronchus and carinal area after necessary excision of same for adenoma is reported. The use of dermal grafts to allow more adequate excision of bronchogenic carcinoma in a patient with restricted respiratory capacity not suitable for total pneumonectomy has also been made successfully. The use of massive grafts to replace large defects of the trachea and left mainstem bronchus following radical right pneumonectomy with resection of the carina is also described. The authors conclude that a major salvage of lung tissue can be accomplished by the use of tracheal and bronchial grafts and that they will also allow more adequate resectional procedures in various types of bronchopulmonary neoplasms.

doctor placement page



NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

AVAILABLE PHYSICIANS

Buckner, Leslie, M., M.D., 937 Carew Tower, Cincinnati 2, Ohio—Age 54; married; Methodist; graduate University of Louisville, 1927; residency Bethesda Hospital, Cincinnati, Ohio; Association in Ob-Gyn with FACS; inactive reserve; has a Georgia license and could be available within 2-3 months.

Chambers, Robert E., M.D., Duke Hospital, Durham, North Carolina—Age 28; married; Christian; graduate Duke University School of Medicine, 1952; residency Duke Hospital; Diplomate National Board; Category IV; specialty Pediatrics; available May 1956.

Coleman, Ermin E., Jr., M.D., Route No. 2, Box 1, Pineville, Louisiana—Age 30; married; 2 children; graduate Alabama Medical College, 1953; residency GP at Huey P. Long Charity Hospital, Pineville, Louisiana; Category IV; interested in general practice in the southeastern area; available July 1, 1955.

Ehle, Jack F., M.D., 1600 Asbury Avenue, Winnetka, Illinois—Age 36; married; Protestant; graduate Chicago Medical School, 1946; residency Michael Reese Hospital, Chicago, Illinois; interested in general surgery in clinic or as assistant or associate; available July 1956.

Ferguson, Emmett, Jr., M.D., Duval Medical Center, Jacksonville, Florida—Age 34; married; Baptist; graduate Medical College of Georgia, 1950; 4 years general surgery residency; reserves; interested in general surgery; size of community preferred, 25,000 up; prefers partnership or single practice; available August 1, 1955.

Fletcher, William E., M.D., 3534 Stanford Place, Dayton 6, Ohio—Age 30; married; Protestant; graduate Western Reserve University, 1949; residency Cleveland City Hospital and VA Hospital; 3 years formal training general surgery; 2 year preceptorship general surgery; interested in general surgery in clinic or as an assistant or associate; available July 1956.

Gillikin, Wm. Vernon, M.D., Columbus City Hospital, Columbus, Georgia—Age 30; married; Baptist; graduate Bowman Gray School of Medicine, 1954; interested in general practice in clinic; available July 1955; intern at present and interested in ob-gyn but if could find something interesting would consider general practice.

Hanberry, Richard L., Jr., M.D., 177 First Avenue, S. E., Atlanta, Georgia—Age 32; married; Episcopalian; graduate Medical College of Georgia, 1951; residency Grady Memorial Hospital, Atlanta; specialty Ob-Gyn; available August 1, 1955.

Hardegree, Harvey C., Jr., M.D., 26 Valley Road, Apt. 7, Drexel Hill, Pennsylvania; Age 34; married; Protestant; graduate University of Oklahoma, 1950; Board eligible general surgery; interested in general surgery in clinic, industrial; available July 15, 1955.

Hobart, Seth G., Jr., M.D., University of Virginia Hospital, Charlottesville, Virginia—Age 36; Married; 3 children; Protestant; graduate University of Virginia Medical School, 1950; residency University of Virginia Hospital; 3 years general surgery; 2 years otolaryngology; Board qualified in otolaryngology; Category IV; specialty otolaryngology and major head and neck surgery; available July 1, 1955.

Howard, Hugh David, M.D., 1206 Roosevelt Road, Broadway, Illinois—Age 33; married; Protestant; graduate Northwestern University, 1947; residency VA Hospital, Hines, Illinois; completed three year approved residency in medicine; now Board eligible; presently in practice with VA, would like to go into private practice; Priority IV; specialty internal medicine; prefers clinic, or as assistant or associate; available anytime.

Johnson, B. T., Jr., M.D., 202 South 3rd Street, McGehee, Arkansas—Age 32; married; Baptist; graduate Arkansas Medical School, 1951; presently in practice, desires to relocate; interested in general practice in Georgia in clinic or as an assistant or associate; available immediately.

Johnson, Richard Chadwick, M.D., P. O. Box 304, Sand Springs, Oklahoma—Age 34; married; Presbyterian; graduate Yale University, 1945; residency Hillcrest Memorial Hospital, Tulsa, Oklahoma, one year surgery—University of Virginia Hospital, Charlottesville, Virginia, one year medicine—eight months residency credit in medicine USN; six years practice of internal medicine; presently in practice, would like a larger community not predominantly industrial and one that has more cultural advantages for family; Priority IV; specialty internal medicine; available in about 60 days following notice; will not accept any "practices for sale."

McConnell, Ben H., M.D., Box 664, Beltsville, Maryland—Age 36; married; Episcopal; graduate Georgetown University, 1950; interested in general practice as student health physician with any school, college or university; available at once.

Melcher, Truman O., M.D., ENT Clinic, John Sealy Hospital, Galveston, Texas—Age 41; married; Protestant; graduate University of Texas School of Medicine, 1942; residency John Sealy Hospital; member AMA; specialty otolaryngology and endoscopy; available September 1, 1955.

Richardson, B. A., M.D., 544 West 2nd Street, Lexington, Kentucky—Age 28; married; Methodist; graduate University of Tennessee, 1954; interested in general practice in Georgia; available August 1, 1955.

Rolfes, Harry Franklin, M.D., 1104 N. Shadview Terrace, Birmingham 9, Alabama—Age 35; married; Catholic; graduate University of Maryland, 1944; has been in resident training, now wishes to locate for first time in ophthalmology; Category IV; prefers clinic; available July 1955.

Roth, Robert Earl, M.D., USVA Hospital, Nashville 5, Tennessee—Age 30; married; Protestant; graduate University of Illinois, 1949; residency VA Hospital, Nashville, Tennessee; specialty radiology; available August 1955.

Williams, David J., Jr., M.D., US Naval Hospital, Bethesda, Maryland—Age 36; married; Baptist; graduate University of Cincinnati, 1943; residency Naval hospitals in California and Pennsylvania; certified by American Board of Surgery; now in service; specialty general surgery; prefers clinic or to be an assistant or associate; available July or August 1955.

Wilson, James Woodfin, Jr., M.D., Essex County Sanatorium, Verona, New Jersey—Age 32; married; graduate Louisiana State University, 1948; residency Confederate Memorial Medical Center (internal medicine) one year; Essex County Sanatorium (pulmonary disease, at present); Priority IV; interested in general practice in clinic with emphasis on internal medicine, as assistant or associate or industrial; available about July 1, 1955.

Wimberly, John A., M.D., 909 North Broadway, Lexington, Kentucky—Age 29; married; Methodist; graduate University of Louisville, 1952; residency St. Joseph Hospital; will finish one year general surgery July 1, 1955; Priority IV; available July 1, 1955.

AVAILABLE LOCATIONS

Arlington, Georgia (Calhoun County)—Population 1,382. In need of doctor-surgeon for practice in new excellently equipped 16-bed hospital, located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia.

Broxton, Georgia (Coffee County)—Population 3,500—Doctors clinic available; also home available; 60 room county hospital at Douglas; seven room doctors building; no physician in area; physician will have more work than he can do. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia.

Dillard, Georgia (Rabun County)—Population 2,500. Doctor's office to be furnished rent free for one year; would rent five or six room house, fully equipped kitchen, county hospital at Clayton; drug store and pharmacist; good schools; doctor would be welcome right now; late doctor had an excellent practice; other benefits considered in a short time; active church groups and community club that would be happy to assist doctor. Contact: Mrs. L. Neville, Dillard, Georgia.

Edison, Georgia (Calhoun County)—Population 1,245. Two physicians in area; Hill-Burton Hospital (1 mi.); one clinic local with 10 beds, x-ray, lab equipment, operating room with instruments; rental \$75.00 (maximum \$100.00) per month; two excellent drug stores; housing available for rent at \$30-\$40; good elementary and high schools; five churches; great need for a physician in this community. Contact: Dr. J. S. Beard, Edison, Georgia.

Hampton, Georgia (Henry County) — Population 1,000—No doctor in Hampton, nearest 10 miles away; hospital in Griffin; office space, housing available; contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia.

Smithville, Georgia (Lee County) — Population 700—No physician in area; home in Leesburg, office downtown rent free; completely equipped office of two rooms and connecting lavatory with outlets for sterilizers, etc., attached. All

private practice available. Contact: Mr. Charles A. Dean, Smithville Drug Store, Smithville, Georgia.

Unadilla, Georgia (Dooly County) — Population 1,200—Dooly County Hospital owned and operated by the people of the county; office space available or will build small clinic and let doctor rent or buy. Housing will be provided rent reasonable or can get house built to suit. They guarantee a good doctor will do well; one physician in area, age 75.

Contact: Mr. E. H. Conner, Unadilla, Georgia.

Woodbine, Georgia (Camden County)—Population 1,000. Small, fully equipped office and clinic available; ample office space, delivery room, laboratory (inc. x-ray), nursery, wards, private rooms; five room wooden dwelling adjoins hospital available at \$35.00 mo.; one other doctor in Woodbine, doctor is needed now. Contact: Dr. S. C. Atkinson, Waverley, Ga.

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ANNOUNCEMENTS

The Georgia Diabetes Association was organized May 2, 1955, during the Annual Session of the Medical Association of Georgia. This organization is designed to stimulate interest in diabetes among the physicians of this state.

Plans are being made to organize subsidiary lay groups. Through these agencies a program of public education will be fostered with particular emphasis on education of the diabetic in the care of his disease. Such a group has been active in Atlanta for some time.

The Georgia Diabetes Association will guide these lay groups, furnish speakers to medical societies on request, and offer all possible help in the diagnosis and treatment of diabetes. Plans for an active research program are being considered.

At the first meeting officers were elected. Christopher McLoughlin, Atlanta, is president; George R. Dillinger, Thomasville, vice-president, and Alex T. Murphey, Augusta, secretary-treasurer.

The next meeting will be held in Atlanta in September. At that time a constitution will be established and plans made for obtaining a suitable visiting speaker for the next MAG Annual Session. Problems of organizing local lay groups will be discussed. Guy H. Adams, C. R. Arp, and E. Van Buren of Atlanta are in charge of arrangements for this meeting.

All physicians interested in diabetes are cordially invited to join. Dues are four dollars (\$4.00) per year. Checks should be made out to The Georgia Diabetes Association and mailed to:

Dr. Alex T. Murphey, Secretary-Treasurer
Georgia Diabetes Association
1132 Druid Park Ave.
Augusta, Georgia

All joining prior to the September meeting will be classified as charter members.

It is sincerely hoped that the enthusiasm in this society will continue. Care of the diabetic always presents problems, and this organization hopes to offer some help to Georgia physicians in solving them.

Post Graduate Course in Pediatric Allergy—New York Medical College, Flower and Fifth Avenue Hospitals, each Wednesday, November 2, 1955, through May 31, 1956. Applicants must be certified in pediatrics or have the requirements for certification. Enrollment limited, fee \$300.00. Research fellowship in Pediatric Allergy available. Apply: Office of the Dean, New York Medical College, Fifth Avenue at 106th Street, New York 29, N. Y.

Directory—"Cancer Services and Facilities in the United States, 1954"—Compiled by the National Cancer Institute, can be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for 45 cents a copy.

Short Course in the Clinical Pathology and Pathology of Parasitic Diseases—August 15-17, 1955, Louisiana

State University School of Medicine, New Orleans, La. The fee for the course is \$50.00. For further information write to Dr. Clyde Swartzwelder, Dept. of Microbiology, L. S. U. School of Medicine, 1542 Tulane Ave., New Orleans 12, La.

Tennessee Valley Medical Assembly—Read House, Chattanooga, Tenn., October 3 and 4, 1955. This meeting is sponsored by the Chattanooga and Hamilton County Medical Society and will have approximately 16 nationally known guest speakers. For reservations write to: Chattanooga, Inc., 819 Broad Street, Chattanooga, Tenn.

DEATHS

EMMETT ETHERIDGE BUTLER, Gainesville, died at his home on May 5, 1955, after a long illness. He was 47 years of age.

Dr. Butler was born in Jeffersonville. He received his education in the Macon schools and at Morehouse College, Atlanta; he was graduated from Meharry Medical College, Nashville, Tennessee, in 1934. Dr. Butler practiced in Macon and Alto before going to Gainesville in 1936.

A past president of the Georgia State Medical Association, he was treasurer of the Northeast Georgia Medical Association and treasurer of the North Georgia Medical Association. He was one of the first two Negroes named to the Gainesville Board of Education.

He is survived by his widow and one daughter, Mrs. Kathryn Butler Carter, of Gainesville.

RANDALL P. KENDALL, JR., Columbus, died unexpectedly on May 7, 1955, of a heart attack. He was 39 years old.

A native of Cordele, Dr. Kendall had lived in Columbus three years. He received his medical training at the Emory University School of Medicine and served his internship at Columbus City Hospital. At the time of his death he was Muscogee County Medical Examiner.

Always active in civic affairs, he was in a runoff for election as vice-president of the Columbus Sertoma Club at the time of his death.

Survivors include his wife, the former Margaret Bowen of Columbus; his parents, Mr. and Mrs. R. P. Kendall, Sr., of Macon; two sons, Randall P., III, and William P.; and a daughter, Rebecca Lynn.

Funeral services were held on May 9th at the First Baptist Church. Pallbearers were A. B. Conger, W. P. Jordan, W. R. Snellings, C. D. Johnson, Polk Land, and Harry Brill, all of Columbus. The other members of the Muscogee County Medical Society here honorary pallbearers.

SOCIETIES

The FIRST DISTRICT MEDICAL SOCIETY held its regular spring meeting on May 18, 1955, at the Forest Heights Country Club, Statesboro. The meeting was called to order by the president, John Mooney, Jr.,

Statesboro. He introduced H. Dawson Allen, Jr., Milledgeville, president of the MAG, who made a short talk. The following doctors presented scientific papers: A. H. Center, Savannah—"Use of Thorazine and Serpasil in Disturbed Patients"; Ellison R. Cook, III, Savannah—"Medical Uses of Procaine"; V. P. Sydenstricker, Augusta—"Collagen Diseases"; J. R. Winburn, Jr., Savannah—"McVay Herniorrhaphy Procedure"; and Henry C. Frech, Savannah—"Use of Thorazine in Obstetrics." Case reports were presented by the following: C. T. Brown, Guyton—"Unusual Case of Fecal Impaction"; and J. W. DeReamer, Savannah—"Multiple Basal Cell Carcinoma of Skin." The following officers were elected: president-elect, William Simmons, Sylvania, and vice-president-elect, Lee Howard, Jr., Savannah; John Elliott, Savannah, is president. After the business meeting was concluded, a social hour and banquet were held at the Forest Heights Country Club. Approximately 100 people were present to hear an address by Mr. James Saxon Childers, Editor of *The Atlanta Journal*.

The THIRD DISTRICT MEDICAL SOCIETY met on May 12, 1955, with the Georgia Tuberculosis Association. The meeting was held in Columbus, and the featured speaker of the meeting was Mr. Herman Talmadge, former governor of the State of Georgia. Mr. Talmadge recounted some of the important improvements in tuberculosis control during the six years he held the office of governor. John Stapleton, Columbus, Third District Medical Society president, presided at the first session. Other physicians on the program were Robert J. Anderson, U. S. Public Health Service; Raymond F. Corpe, superintendent of Battey State Hospital, Rome; George W. Comstock, Columbus; Osler A. Abbott, Atlanta; and Rufus Payne, Augusta.

An organizational meeting of the new CHATTAHOOCHEE MEDICAL SOCIETY, comprising the physicians of Forsyth and Gwinnett counties, was held at 6 p.m., Wednesday, May 25, 1955 at Mashburn's Lake, Cumming.

Present were Marcus Mashburn, Sr., Marcus Mashburn, Jr., James S. Mashburn, all of Cumming, and Rupert Bramblett, Silver City, all members of the old FORSYTH COUNTY MEDICAL SOCIETY. Present from the former GWINNETT COUNTY MEDICAL SOCIETY were Harry Hutchins, Buford; Sylvester Cain, and W. W. Puett, both of Norcross; and John Mauldin, Fayette Sims and Dan Martin, all of Lawrenceville. Guests included David Henry Poer, Atlanta, Secretary-Treasurer of the MAG; A. H. Letton and Raymond Arp, both of Atlanta, and Mr. John F. Kiser, of the MAG headquarters office.

After a dinner served by the Mashburns at their lake, the meeting got under way. New officers elected were as follows: Harry Hutchins, Buford, president; Rupert Bramblett, Silver City, vice-president; Fayette Sims, Lawrenceville, secretary; Marcus Mashburn, Sr., Cumming, delegate, and D. C. Kelley, Lawrenceville, alternate delegate. It was decided that the officers would act as a Board of Censors. A Constitution and By-Laws Committee was appointed consisting of Sylvester Cain, Norcross, chairman, and Marcus Mashburn, Sr., Cumming.

It was voted that the society will meet the third Wednesday of the month, approximately four times a year. The next meeting will be held in Gwinnett County. James S. Mashburn, Cumming, was appointed program chairman.

DEKALB COUNTY MEDICAL SOCIETY members and their wives were the guests of the Stone Mountain General Hospital at a barbecue recently.

FULTON COUNTY MEDICAL SOCIETY was host for the Atlanta showing of the closed circuit telecast program on "Mind and Medicine." Some 100 doctors saw the program at an Atlanta hotel. Via TV spectators traveled to medical centers in the U. S., England, and Belgium where mental ills are treated. The program was sponsored by the AMA and the American Psychiatric Association in cooperation with the Smith, Kline and French Laboratories.

HALL COUNTY MEDICAL SOCIETY held its April meeting on April 19, 1955, at the Wheeler Hotel in Cornelia. A program was presented by Physician's Services, Inc., and Blue Cross and Blue Shield programs were discussed.

The organizational meeting of the OCONEE VALLEY MEDICAL SOCIETY was held on May 12, 1955, at the residence of Lee Parker, Greensboro. After a barbecue furnished by George Green, Sparta, the business meeting was held at the Minnie G. Boswell Hospital in Greensboro. Lee Parker was elected president, and other officers are C. H. Dickens, Madison, vice-president; George Green, secretary; and J. H. Nicholson, Madison, delegate. Elected to the Board of Censors were C. S. Jernigan, Sparta, chairman; C. H. Dickens and F. H. Killam, Greensboro. Dr. Parker appointed a Constitution and By-Laws Committee to consist of Harry L. Cheves, Jr., Union Point, chairman, and H. A. Thornton, Greensboro. H. Dawson Allen, Jr., Milledgeville, President of the MAG, gave a talk on the importance of the general practitioner. Remarks were also made by H. L. Cheves, Union Point, Tenth District Councilor, and Mr. John F. Kiser, of the Atlanta headquarters office. Robert Coggins, Augusta, presented a paper on "Hypertension." This new society is composed of physicians of Hancock, Greene, Morgan, and Taliaferro Counties. It was organized because of the fact that the separate county societies were too small to be active. The new organization is cordially welcomed into the fold of the 70 odd component medical societies of the Medical Association of Georgia.

RICHMOND COUNTY MEDICAL SOCIETY had as the principal speaker at its meeting on April 26th, Richard Van Fletcher, prominent Chattanooga surgeon. His subject was "Gallbladder Disease and Some of Its Complications."

WARE COUNTY MEDICAL SOCIETY met on May 5th at the Okefenokee Golf Club in Waycross. Delegates W. L. Pomeroy, Leo Smith, and Neal F. Yeomans presented a report of the 105th Annual Session of the MAG, held in Augusta May 1-4, 1955. At this meeting the members decided on a uniform fee of \$5.00 per shot for the Salk vaccine shots. A. W. DeLoach and Walter Lee were hosts for the meeting.

PERSONALS

First District

ELLISON R. COOK, III, Savannah, reviewed the new book by William B. Terhune entitled *Emotional Problems and What You Can Do About Them*, at the Downtown Library on May 6th. The review was one in a series of monthly book talks at the library. In speaking about the book, Dr. Cook said, "I am not in perfect agreement with Dr. Terhune's ideas here. He is a well-known psychiatrist, with his feet on the ground, but his book is written for little minds, for mentally lazy people, who do not think very much."

Ernest G. Edwards, former orthopedic surgeon in Savannah and Columbia, S. C., returned in April to Savannah and has opened offices at 512 Abercorn Street for the practice of orthopedic surgery.

A New York psychiatrist, formerly at Hunter Air Force Base, has been added to the staff of the Chatham-Savannah Mental Health Clinic. Gabriel D'Amato, senior psychiatrist at the Catholic Charities Guidance Institute in New York City, will begin his new duties in Savannah on July 1, 1955. A graduate of Seton Hall University, Dr. D'Amato received his M.D. degree from the Columbia University College of Physicians and Surgeons in 1947. He is also a diplomate of the National Board of Medical Examiners. He received his psychiatric training at the Bronx VA Hospital; at Creedmoor State Hospital, Long Island, N. Y.; the Child Guidance Institute of the Brooklyn Jewish Board of Guardians, and at the Post-Graduate Center for Psychotherapy in New York.

S. C. RUTLAND, Atlanta, was named to serve on the executive committee of the Georgia Public Health Association.

Announcement has been made of the marriage on May 21, 1955, of Miss Ruby Edwardena Shepard to WILLIAM V. LONG, Savannah. Mrs. Long is a native of Rhine, Georgia, and a graduate of the Warren A. Candler Hospital School of Nursing. Dr. Long is a graduate of the Emory University School of Medicine.

Second District

W. L. BRIDGES, Tifton, discussed polio and the development and use of the new Salk polio vaccine in a talk before the Exchange Club of Tifton recently.

James B. Hicks, Donalsonville, has recently become associated in practice with E. E. MOSELEY at the Moseley Clinic and Hospital. A native of Alabama, Dr. Hicks received his B.S. degree from the University of Alabama and his M.D. degree from Johns Hopkins Medical School. He was associated with the Lahey Clinic, Boston, for more than 11 years following his graduation, and before coming to Donalsonville he practiced surgery in Montgomery, Ala.

Moultrie's new baseball field will be named in honor of the late EDGAR C. HOLMES, Moultrie, who died on April 13, 1955. Dr. Holmes was president of the Little League at the time of his death and also team physician for the high school athletic department. The name of the field will be the "Edgar Holmes Memorial Stadium."

H. B. JENKINS, Donalsonville, who has recently returned from a trip to England and the Continent, showed

slides of his trip at a meeting of the Pineview Community Improvement Club.

FREDERICK H. THOMPSON, Albany, who is pathologist at the Phoebe Putney Hospital, has been certified by the American Board of Pathology, in clinical pathology. He is also certified by the American Board of Pathology in pathological anatomy.

Harry H. Williams, a native of New York City, has recently opened an office in Attapulcus for the general practice of medicine. Dr. Williams received his medical education at Kirksville (Missouri) College and Philadelphia (Pennsylvania) College. For the past 20 years he has been engaged in general practice in Missouri and West Virginia.

Third District

MERCER BLANCHARD, Columbus, was the subject in a recent "Typewriter Portrait," a feature article in the *Columbus Ledger*. Particular emphasis was placed on the fact that Dr. Blanchard has been school medical officer for the past 38 years. Dr. Blanchard said he considered as the high point of his career, in connection with the schools, the polio immunization program. Dr. Blanchard also serves as chief of pediatric service at City Hospital.

LEONARD T. MAHOLICK, Columbus, address a recent meeting of the Columbus Exchange Club. He listed as five aids to preventing nervousness "work, play, friends, talking, and listening." Dr. Maholick is director of the new Bradley Guidance Center.

R. C. PENDERGRASS, Americus, director of the Americus Cancer Clinic, spoke at a recent weekly meeting of the Americus Kiwanis Club. Dr. Pendergrass discussed the work being carried on by the American Cancer Society in an effort to conquer cancer. Following his talk, a motion picture entitled, "The Doctor Speaks His Mind," was shown.

CHARLES R. SMITH, Columbus, addressed a recent meeting of the Carver Junior High School P.-T.A. on "Mental Health."

Fourth District

People from 14 counties, four states and one foreign country came to The Rock on May 1, 1955, to honor CLAIBORNE A. HARRIS and Mrs. Harris. Dr. Harris has devoted nearly 50 years to caring for others, and 500 former patients and friends came to take part in the "Appreciation Day." A loving cup was presented to Dr. and Mrs. Harris by the Home Demonstration Club, and a Bible was given them by The Rock Baptist Church.

WILLIS M. HENDRICKS, LaGrange, led two programs in the series on marriage conducted in LaGrange recently. The program both times included a film and discussion.

E. V. PATRICK, Carrollton, was guest speaker at a recent meeting of the Hulett Community Club. He spoke on the new Salk polio vaccine and discussed how shots would be given. A question and answer period was held after the lecture.

J. A. SAMRA, Hapeville, has reported for active duty with the rank of major with the Army Medical Corps in San Antonio, Texas.

Fifth District

DONALD S. BICKERS, Atlanta, has been certified by the American Board of Neurosurgery.

W. E. BURDINE, Atlanta, has been elected president of his class at the Woodrow Wilson College of Law in Atlanta.

C. E. CUNNINGHAM, ROBERT P. SHINALL, and JOHN R. HEARD, Decatur, have been granted approval of their plan to erect a three story, \$195,000 doctors' building on East Ponce de Leon, in Decatur. The building will occupy two lots, and provision has been made for parking area around the building.

Honor guests at a recent luncheon meeting of the Georgia Association of Laryngectomees were MURDOCK EQUEN, ROBERT BROWN, and ELIZABETH GAMBRELL, of the Ponce de Leon Infirmary, Atlanta.

Governor Marvin Griffin has appointed six medical and drug leaders to form the Georgia Advisory Committee on Polio Vaccine; they are C. DIXON FOWLER, W. J. MURPHY, JOHN H. VENABLE, W. F. FRIEDWALD, Mr. J. L. Hawk, all of Atlanta, and PETER HYDRICK, College Park.

WILLIAM F. FRIEDWALD, Atlanta, is director of the unit at St. Joseph's Infirmary which will treat acute polio patients, admitted under a new hospital program. St. Joseph's thus becomes the first private hospital in Atlanta to admit such patients; it will supplement services offered by Grady Memorial Hospital. After a case has passed the acute stage, the patient will be taken elsewhere for further treatment.

A. H. LETTON, Atlanta, was the principal speaker at the annual meeting held in April of the Carroll Chapter, American Cancer Society. Dr. Letton stressed the fact that gains are being made against cancer, and the importance of education side of the Cancer Crusade, for which the dinner attended by over 100 served as a kick-off.

A. H. LETTON, Atlanta, attended the annual meeting of the American Goiter Association in Oklahoma City.

In an address to the Atlanta Rotary Club, ARTHUR P. RICHARDSON, Emory University, said that Atlanta has all the elements necessary for the development of a great medical center. He said, "We have or will have with the completion of current building programs (at Piedmont Hospital, St. Joseph's Infirmary, and Grady Memorial Hospital) unsurpassed physical facilities. Atlanta has an excellent group of private physicians; local and state governments that fully recognize their important position in the health picture, and an outstanding medical school." He also said that construction of a large, new Emory Clinic building to house the offices of 50 to 70 physicians who will practice medicine together is expected to begin very soon.

GERALD R. SUTTERFIELD, Atlanta, formerly associated with the Buckhead Clinic, has moved into private offices in the Maple Drive Professional Building. Dr. Sutterfield specializes in obstetrics and gynecology.

R. C. WILLIAMS, Atlanta, spoke to the Southeast Georgia Council of the Georgia Hospital Association at their meeting the first part of May. He announced that the Hill-Burton hospital program funds for this year will be approximately the same as last year. He said that 45 hospitals have been built in the state with Hill-Burton funds and 12 hospitals have been enlarged. At the present time 10 new hospitals are being built in the state and five are being enlarged.

Announcement has been made of the forthcoming marriage of Miss Susan Redfield, of Atlanta, to EDGAR WOODY, JR., Atlanta, Editor of the *Journal*.

Sixth District

Three Macon physicians were honored recently for their work with the Macon Young Men's Christian Association. They are CARL ANDERSON, FRANK M. HOUSER, and WILLIAM L. BARTON. Dr. Anderson has been on the board of trustees, and Dr. Houser is a member of the board of directors.

Dr. and Mrs. BRASWELL E. COLLINS, Macon, sailed June 10th on the S. S. United States for six weeks' in Europe. They will visit their brother, Lt. Col. Fred Collins, and his family in Paris. Dr. Collins will also attend clinics at New Hospital in Paris, University Hospital in Zurich, and the Royal Eye Hospital and Moorfields Hospital in London.

M. FERNAN-NUNEZ, Dublin, addressed the Laboratory Section of the Georgia Public Health Association at its annual meeting in Savannah, April 25. His topic was "The Pathogenic Spirochaetes"; it was illustrated with original motion pictures taken through the dark field microscope.

Marvin Harris, Macon, who organized the Macon Hospital blood bank in 1946 and has directed it since that time, has resigned to join the U. S. Public Health Service. Future operation of the Macon Hospital blood bank will be under the direction of LEONARD H. CAMPBELL, who heads the hospital laboratory.

H. B. Jones, Augusta, has announced plans to go into general practice in Gray and Monticello when he finishes this year of residence at the University Hospital in Augusta. Dr. Jones will be on the staff of the hospital in Monticello; he will live and spend each morning there and keep afternoon office hours in Gray.

JOHN R. LEWIS, JR., Atlanta, addressed the meeting of the International College of Surgeons in Geneva. Dr. Lewis sailed from New York on the Queen Mary on May 11th. He visited Paris and parts of Germany before going to Switzerland. After the meeting he toured Switzerland, Germany, Italy, and England. He sailed from Southampton on June 14th.

J. R. SHANNON MAYS and T. M. HALL, Macon, were on a panel to discuss Psychiatry and Practice of Medicine at the annual meeting of the Georgia Association for Mental Health.

Luther P. Pennington, formerly of Melbourne, Fla., has recently moved to Louisville to take over the running of the Jefferson Hospital. Dr. Pennington has bought a 49 per cent interest in the hospital; James Pilcher, Louisville, owns the remaining 51 per cent. Dr. Pilcher

has been forced by poor health to give up his active practice. Mrs. Pilcher will continue in her position as hospital administrator. Dr. Pennington is a native of Matthews, Georgia, and he and Dr. Pilcher have been life long friends.

Seventh District

C. M. SMITH, Rockmart, was guest speaker at a recent meeting of the Rockmart Rotary Club. He spoke on the cost of drugs and pointed out the reasons for the great expense of some drugs.

O. R. STYLES, Cedartown, has recently returned from an extended stay in Florida; he is resuming practice in his offices in the West Theatre Building.

Eighth District

W. W. SHARPE, Alma, has announced that Ohlin Wilson, now in training at the University Hospital in Augusta, will begin practice in Alma with him in August. Dr. Wilson is a graduate of the University of Virginia Medical School and interned at Richmond (Virginia) Hospital. Dr. Wilson will share Dr. Sharpe's offices in the Lee Drug Store building.

Ninth District

C. L. AYERS, Toccoa, who was recently named the "General Practitioner of the Year," received a shower of congratulatory letters written by 55 fellow-members of the Toccoa Kiwanis Club. They were bound in a book and presented to him at a meeting on May 10th. After receiving the book of letters, Dr. Ayers told some of the incidents that took place in the early days of his 53 year old practice.

When "Doctor Jack" (SYLVESTER CAIN, Norcross) returned to work after an illness of several weeks he found his office completely done over. Some 200 friends of his from both Norcross and Duluth contributed time, labor, and money for the renovation. Dr. Cain had entered Emory University Hospital on March 1st, and he did not return to his office until April 30th—only to find that the key did not work. The new door was only the beginning.

EDWIN H. ETHERIDGE, formerly of Winder, wrote to the Ninth District secretary to say that he is now stationed at the U. S. Naval Dispensary in Washington, D. C.

Dr. and Mrs. MARCUS MASHBURN, JR., Cumming, announce the birth of a son on April 19, 1955; he has been named Burt Maynard. The Mashburns have four other children, Martha, Marguerite, Catherine, and John Marcus.

WILLIAM H. NICHOLS, Canton, who has been a member of the staff of Coker's Hospital since August 1952, has opened an office for the private practice of medicine. His offices will include a waiting room, two examining rooms, X-ray room, and laboratory, but no space for bed patients. Dr. Nichols is a graduate of the Medical College of Georgia and he interned at Brooke General Hospital in San Antonio, Texas.

Dr. and Mrs. W. BRUCE SCHAEFER, Toccoa, attended the State Democratic Executive Committee meeting held recently in Atlanta. Mrs. Schaefer is a member of the committee.

Tenth District

John Mars Caldwell, U. S. Army Medical Corps, has been appointed chairman of the department of psychiatry at the Medical College of Georgia. A native Augustan, Dr. Caldwell is now chief of psychiatry and neurology at Letterman Army Hospital in San Francisco, Cal. He will assume his new duties in Augusta in the fall.

POMEROY NICHOLS, Augusta, addressed members of the Central Savannah River Area Association for the Help of Retarded Children recently. His subject was "Hydrocephalus." Following his talk a movie was shown, and the session was closed with a question and answer period.

VIRGIL P. SYDENSTRICKER, Augusta, was one of the speakers at the seventh annual convention of the Georgia Society of Medical Technologists, held in Augusta, May 20-22, 1955. Another speaker was ROBERT HAUSMANN, Atlanta.

RICHARD TORPIN, Augusta, and Mrs. Torpin attended the annual meeting of the North Carolina Medical Association which was held in May at Pinehurst, N. C.

News from the Southern Medical Association

The meeting in *Houston*, November 14-17, is building-up rapidly, and the request for reservations is phenomenal. Those who are going should seek reservations at once. It will be of interest generally to know that recently Thomas Spies, the world famous nutritional expert, and Mr. C. P. Lorz, the Advisor and Professional Relations Counselor to the Southern Medical Association, were honored by the Cuban Red Cross, both gentlemen receiving the rank of Comendador in the high Order of Honor and Merit of the Cuban Red Cross. Such honor and recognition on the part of our Cuban confreres signifies and exemplifies the cordial good relations that continues between the Southern Medical and our friends in the Republic of Cuba.

Please send your news to . . .

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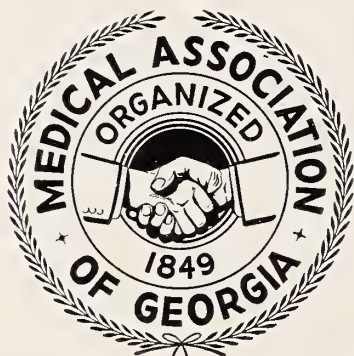
Cover photo by Ted F. Leigh, M.D., is of a physician studying the x-ray of a rheumatic heart. For more on rheumatic fever and rheumatic heart, see pages 362 & 367.

106TH ANNUAL SESSION

May 13-16, 1956 — Atlanta Biltmore Hotel



FIRST CALL for SCIENTIFIC PAPERS



Titles of papers should be submitted immediately to the respective program chairmen listed below.

All titles must be submitted before September 30, 1955

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518 Marshall St., Decatur

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Edwin L. Rushia, M.D.
Medical College of Georgia, Augusta

Urology

Harold P. McDonald, M.D.
Healey Building, Atlanta

Radiology

Robert M. Tankesley, M.D.
478 Peachtree St., N. E., Atlanta

Diabetes

Chris J. McLoughlin, M.D.
384 Peachtree St., N. E., Atlanta

Injuries of the Knee Joint

JOE KURTZ, M.D., Atlanta, Ga.

NO ATTEMPT will be made to cover the numerous injuries to which the knee is exposed, but rather an attempt will be made to discuss some of the more common injuries in relationship to anatomical and mechanical factors.

Movement and Function

Motion of the knee joint consists primarily of flexion, extension, and rotation. With the knee extended, flexion begins as a hinge action plus internal rotation of the tibia on the femur which reaches maximum in the first 20 degrees. Further flexion is a gliding action made possible by movement between the menisci and the articular surface of the tibia, and by the progressively smaller size of the posterior condyles of the femur. When the knee is extended, all actions are reversed, and the external rotation of the tibia during the final 20 degrees locks the joint securely in extension. The vastus medialis plays its most important role in these final motions and is the main reason why injury, with atrophy of the vastus medialis, is almost always associated with loss of full extension.

The collateral ligaments prevent lateral instability and undue rotation; they are tight when the joint is extended and relaxed when it flexes. The medial is the most important, and its deep portion does not relax entirely during flexion, thus preserving some stability.

The cruciate ligaments are strong intra-articular structures of which the anterior prevents abnormal forward displacement of the tibia and lateral rotation of the femur. The posterior prevents abnormal posterior displacement of the tibia and medial rotation of the femur.

The menisci function as shock absorbers particularly in full flexion and full extension, thus helping prevent damage to the articular cartilage during long periods of weight bearing. They aid stability

by deepening the articulation, and they also help prevent friction. They move backward in flexion and forward in extension, the lateral having approximately three times as much excursion as the medial because of the factor of rotation.

Studies of fresh anatomical specimens in which single ligaments or combinations of ligaments were severed and the effect noted, demonstrate that motion and stability are the result of a finely integrated action of all components.² It is no wonder therefore that the term "internal derangement" has been used so long rather than specific diagnosis of the structures involved.

Diagnosis

From the foregoing it is readily seen that accurate diagnosis is made primarily on a careful history and a thorough physical examination. Modern laboratory aids are usually of little help and even x-ray is limited or inconclusive. It is not always possible for the patient to give exact details as to the force of injury, but he should be questioned relative to his position at the time of injury, direction of the blow, where pain was initially felt, whether he was able to straighten the knee or bear weight, and how soon after injury swelling developed.

Physical examination should be directed towards ascertaining the function of the various joint components. The majority of afferent pain endings are present in the joint capsule, and as a result joint pain tends to be diffuse and poorly localized.³ Careful palpation will usually reveal one area which is more tender, and this aids in diagnosis. Procaine injections of the tender area will likewise aid in allowing more complete examination.¹ The circumference of the thighs and calves should be measured. Joint pain tends to cause a reflex contraction of the flexor muscles and, if severe, spasm with reflex inhibition of the quadriceps muscle results with atrophy as the sequella, particularly of the vastus medialis. If increased fluid is present it should be aspirated and

Presented at the 104th Annual Session of the Medical Association of Georgia, Macon, May 2-5, 1954.

its color and character noted. X-ray examination in the routine AP and lateral views should be made, and, if necessary, special views showing the inferior surface of the patella and the intercondylar notch should also be made. Arthrograms using air as a contrast medium may be done, but in general they are not too helpful.

Joint Effusion and Synovitis

The increased fluid is due primarily to the effect of hemorrhage and the inflammatory response of the synovial membrane. The underlying cause is usually injury to the ligaments, semilunar cartilages, joint capsule or bone. Therefore, the usage of the term "traumatic synovitis" should be avoided until all other causes are ruled out. Traumatic hemarthrosis, on the other hand, is a definite entity and denotes massive hemorrhage into the knee joint, usually the result of the intra-articular fracture or severe soft tissue injury to the peri-articular structures. Swelling in this case usually occurs within 30 minutes and is very painful, whereas effusion not due to severe hemorrhage usually occurs within several hours of injury and causes more discomfort due to pressure rather than actual severe pain. It should be mentioned that extensive tearing of the capsule allows blood and fluid to diffuse into the peri-articular structures, and therefore the size of the swelling is no indication of the extent of injury.

The synovial membrane is richly supplied with blood vessels and, following injury regardless of source, exhibits a typical irritative response consisting of dilatation of the vessels, hyperemia, extravasation of plasma and migration of cellular elements, increase in number and size of synovial cells, and production of larger quantities of mucin. Practically all of the acute effusions contain gross blood to some degree, and the presence of blood acts as a further irritant to the synovial membrane. It follows therefore that the sooner the effusion is removed the less the reaction of the membrane. This is done by aspiration, which is a simple and relatively painless procedure. A healthy respect for the severe damage which can be done to articular cartilage in a relatively short time by pyogenic organisms must be evidenced by strict aseptic technique. The area just above the superior and lateral margins of the patella is infiltrated. The character of the fluid sometimes aids in localizing the injury. If grossly bloody and, particularly, if fat droplets are present, intra-articular fracture is suggested. If blood tinged, rupture of ligaments or synovia is indicated, whereas relative absence of blood would tend to indicate damage to the relatively non-vascular structures such as menisci or articular cartilage. A deep yellow fluid indicates old hemorrhage with breakdown of blood into bilirubin and hemosiderin. Removal of the fluid decreases

the intra-articular pressure and therefore promotes absorption through the lymphatics and by further reducing the irritation of the membrane promotes absorption by phagocytosis. With extremely thick fluid, hyaluronidase can be used to aid absorption.⁷

Following aspiration, a small compression bandage is applied, and the patient is placed at rest or non-weight bearing for a period of seven to 10 days. He is started immediately on quadriceps setting and straight leg raising exercises.

It is best to repeat examination immediately after the aspiration when the discomfort is less, and it should be repeated at intervals until either the patient gets well or a definite diagnosis is made. Failure to do this will result in chronic pain, swelling, stiffness, and disability leading to the picture of chronic traumatic synovitis which has been so well described and so firmly emphasized by Smillie.⁹ Ghormley has likewise emphasized the late degenerative changes which occur in knee joints as the result of inadequate diagnosis and treatment.⁴

Figure 1 illustrates the changes which occur in the synovial membrane in chronic synovitis and shows the thickened edematous walls with many folds and villi producing a membrane which no longer functions normally.

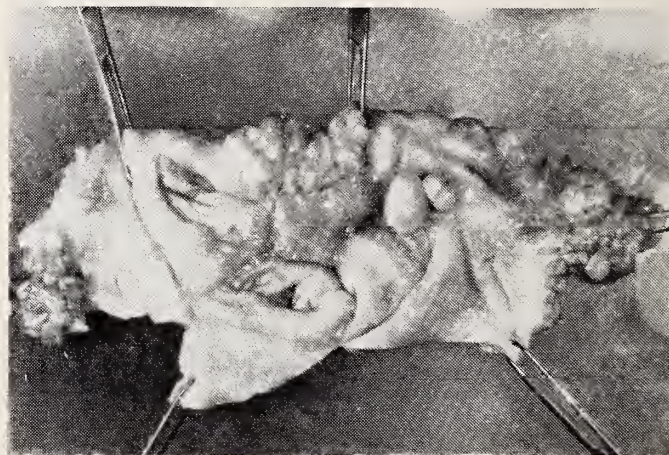


FIGURE 1
Chronic Synovitis.

Occasionally a patient is seen who gives a history of intermittent pain and swelling following trivial injury, and on examination one finds increased fluid, a thickened synovia and capsule, and mild atrophy of the thigh. No definite physical findings indicating involvement of the ligaments is found. If the aspirated fluid has an orange-brown color, one should consider primary involvement of the synovia.

Figure 2 illustrates the appearance of a membrane in pigmented villonodular synovitis. This man had been seen by me for several years when he developed occasional swelling and discomfort which would be relieved by aspirations. They finally became very frequent, and so synovectomy was performed. At operation the synovia was thickened and in some

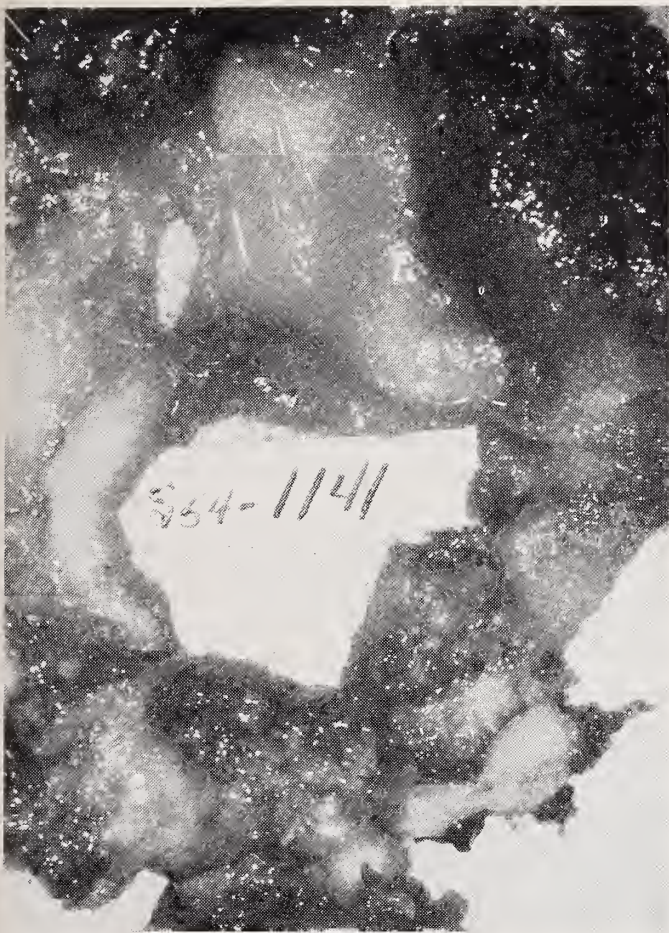


FIGURE 2
Pigmented Villonodular Synovitis.

places had a thick velvety purple-red appearance and in other areas contained firm yellowish nodules.

Figure 3 illustrates the microscopic appearance with its characteristic villi, hypertrophied lining, pigmentation, and the presence of giant cells. The true nature of this condition is not known, but it is felt to be an inflammatory response to an unknown agent.⁶

Bursitis and Calcification

Severe single or repeated trauma to the knee can cause a traumatic bursitis with swelling, pain, and

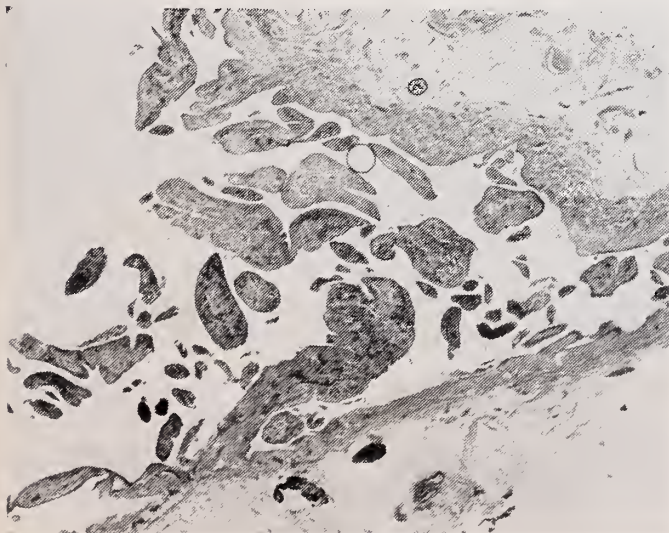


FIGURE 3
Photomicrograph, lower power, Pigmented Villonodular Synovitis.

blood-tinged fluid. These can be handled nicely by aspiration and the instillation of Hydrocortone.⁵ The most common bursa about the knee are well known, and I bring this subject up mainly to call attention to the anserina bursa which is located on the medial side of the knee between the collateral ligament and the inferior surfaces of the tendons of insertion of the sartorius, gracilis, and semitendinosus muscles. Trauma to this area can cause symptoms suggestive of internal derangement, but palpation of the swollen bursa and treatment as outlined above will allow the patient to return to normal function at an early date.

Calcification within the ligaments about the knee may occur just as is seen in the rotator cuff of the shoulder. It is usually the result of acute or repeated trauma with localized necrosis and subsequent deposition of calcium. As the process continues, bone formation may occur, usually at the attachment of the medial collateral ligament to the medial epicondyle.

Figure 4 illustrates such a calcification. This man gave a history of a blow on the lateral side of the leg with immediate pain on the medial side suggestive of a tear of the medial collateral ligament. X-ray revealed this soft area of calcification, and following aspiration of the soft milky material he obtained complete relief. He then admitted having had pain for some weeks which was gradually becoming more severe and which apparently became acute following his last trauma.



FIGURE 4
Calcific Deposit in soft tissue.

Collateral Ligament Injury

These injuries are usually the result of forced abduction, adduction, or severe rotation. The diagnosis rests on abnormal lateral mobility with the joint in 180 degrees of extension. The medial is the most important and is the most frequently injured. If the fibular collateral ligament is suspected, it is important to ascertain the function of the peroneal nerve, which is so often stretched or avulsed by this injury.

Figure 5 illustrates a tear of the medial collateral ligament and shows the abnormal widening of the medial joint space. Treatment if the case is mild consists of aspiration of the effusion and application of a cylinder cast from above ankle to groin with weight bearing for four weeks. Quadriceps setting and straight leg raising exercises are started immediately. If more severe, the cast may be kept on a period of eight to 10 weeks. If very severe, as evidenced by marked lateral mobility, these should be repaired surgically. With injuries of the medial collateral ligament one must be cognizant of the close association of injury to the anterior cruciate and medial meniscus. This constitutes the "unhappy triad" and should have immediate surgical care. The golden opportunity in these cases is lost if one waits too long, as it is much better to repair early than to reconstruct late.⁸

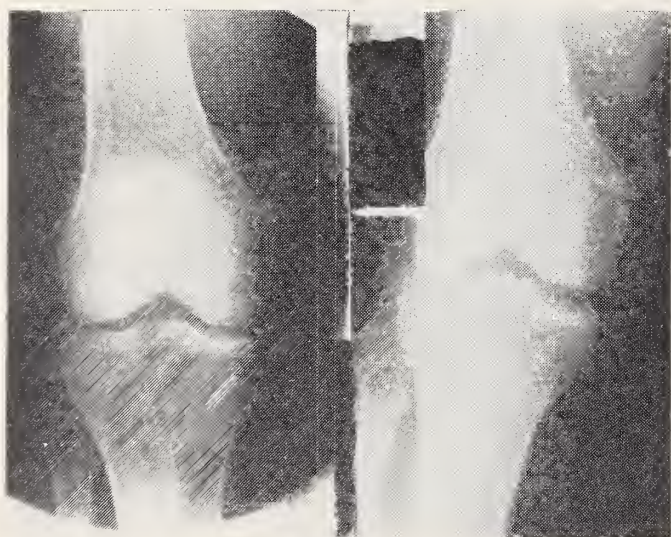


FIGURE 5

Widening of medial joint space due to medial collateral ligament injury.

Cruciate Injuries

The cruciate ligaments are injured in cases of dislocation of the knee or in severe valgus strains with fracture of the tibial plateaus. The posterior is rarely injured other than the result of a direct force against the tibia forcing it back on the femur. The importance of these injuries rests in their association with other injuries and the fact that they usually require surgical correction. Fractures of the tibial spine or the posterior rim of the tibial condyle indicate avulsion injuries to the cruciates.

Meniscal Injuries

Diagnosis is aided by the McMurray test or the various modifications of this test.¹⁰ In essence, the manipulations performed force the torn area against the femoral condyle and cause either subjective pain or a palpable "click." There is a wide range of location and extent of tears possible, and, once the diagnosis is made, the meniscus should be removed. The tears do not heal unless they occur at the synovial or capsular attachment, and it is usually impossible to tell if this condition exists by other than visual examination. In general, the entire cartilage should be removed, although in a bucket handle tear not through the capsular attachment only the mesial segment need be removed.

Figure 6 illustrates a tear of the posterior third in a man who refused surgery. Eleven months after injury and after repeated episodes of pain, locking, and instability he finally consented, and at operation the tear had assumed a polyp-like appearance and would hinge back and forth between the condyles causing his symptoms.



FIGURE 6

Medial meniscus, right knee showing a polyp-like tear.

It is important to emphasize to the patient that, with careful removal and proper instructions on quadriceps exercises prior to and following surgery, good function will be resumed, and thus do much to discard the opinion of so many people that a stiff knee will result from surgery.

Osteochondritis Dissecans

Occasionally one sees a patient with an acute

injury to the knee, and on x-ray examination a defect is seen in the medial condyle. Further questioning usually reveals a history of frequent soreness and a "catch." This condition is essentially one of aseptic necrosis of a small segment of articular bone with degeneration of the overlying cartilage. The treatment is removal of the necrotic cartilage and bone.

Figure 7 (a) illustrates a case of osteochondritis dissecans in a young adult who had an acute injury with tear of medial meniscus. At operation the meniscus was removed; because the articular cartilage overlying this area was not detached and because of its large extent into the weight bearing area, I elected to drill the area in hope of obtaining revascularization.

Figure 7 (b) indicates the appearance eight months later. He incurred another severe injury which caused the area to dislodge and become a loose body.

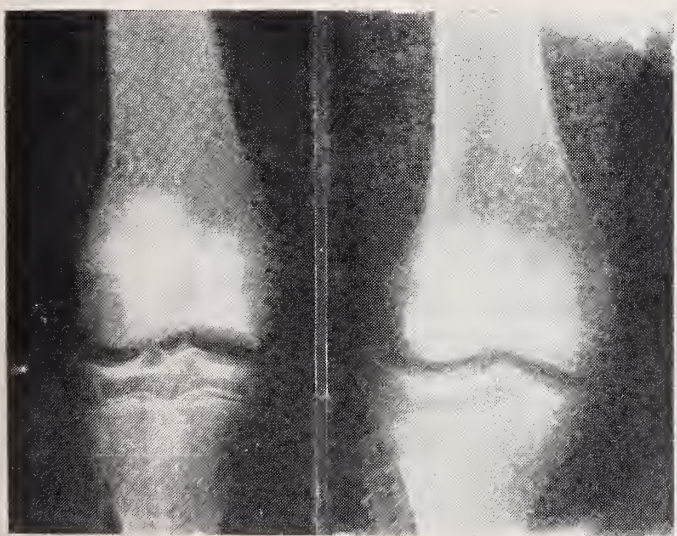


FIGURE 7
(a) Osteochondritis dissecans.
(b) Appearance eight months later.

Figure 8 shows the extent and type of loose body which was removed.

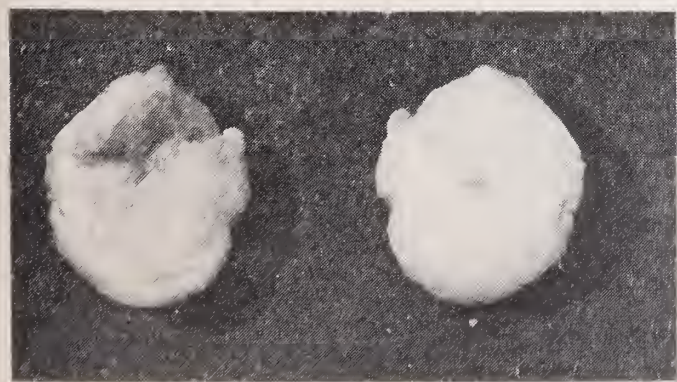


FIGURE 8
Specimen removed from preceding case.
Chondromalacia Patellae

This is discussed because so many patients following minor sprains of the knee complain of persistent pain and "crackling" on weight bearing particularly on going up and down steps. This condi-

tion is a degeneration of the articular cartilage of the patella whose exact etiology is unknown, but in which acute sudden or repeated trauma is present in over two thirds of the cases. The pathology varies from mild softening and fissuring of the cartilage to complete erosion with bony sclerosis and spur formation. When advanced, similar changes occur in the medial femoral condyle as a mirror image.

Figure 9 illustrates the appearance of the articular cartilage and shows the severe fibrillation and degeneration.

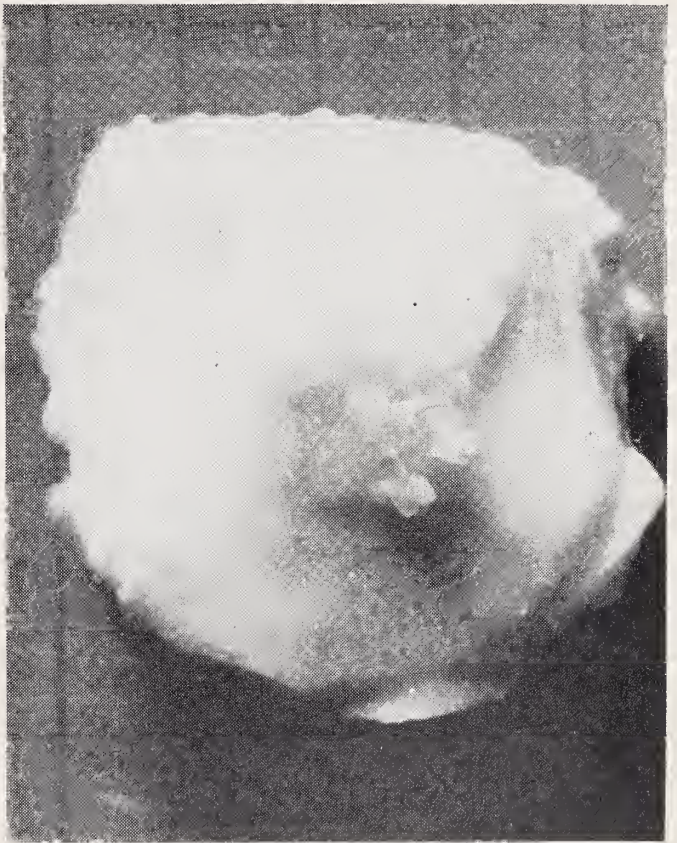


FIGURE 9
Chondromalacia Patellae.

Treatment in the mild cases consist of rest, avoidance of strain, and use of hydrocortisone intra-articularly. Severe cases are best treated by resection of the degenerated cartilage, and patellectomy is reserved only for very severe cases. In general patellectomy is to be avoided if possible.

Quadriceps Exercises

Throughout this paper mention has been made of quadriceps exercises. The importance of this group of muscles in maintaining stability has been emphasized. One must thoroughly understand and impart to the patient the importance of gradual progression from quadriceps setting, to straight leg raising, to progressive resistive exercises if disability is to be avoided. The finest and most careful of conservative or surgical care will be doomed to failure unless followed through with proper muscle re-education.

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7366	John Hamilton Angell	Trustees Garden Lane, Apt. No. 2, 64 E. Broad St., Savannah, Ga.
7367	George A. Arango	1819 Ewing, Houston, Texas
7368	Alfred John Aselmeyer	131 Mt. Vernon Drive, Decatur, Ga.
7369	Jose M. Bahamonde	2920 Edgeworth Dr., N.W., Atlanta, Ga.
7370	Frank Louis Beckel	St. Francis Hospital, Columbus, Ga.
7371	William Edward Bellamy, Jr.	Medical College of Virginia, Richmond, Va.
7372	Norman Herbert Blass	4160 Hylan Dr., Decatur, Ga.
7373	Charles Henry Bloodworth, Jr.	686 Anderson St., Macon, Ga.
7374	Franklyn Philip Bousquet, Jr.	116 E. Jones St., Savannah, Ga.
7375	Leslie M. Buckner	937 Carew Tower, Cincinnati, Ohio
7376	Andrew Jackson Causey	3890 Wieuca Terrace, N.E., Atlanta, Ga.
7377	Clinton Beriah Chandler	1520 Richmond St., Brunswick, Ga.
7378	Louis Guy Chelton	531 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta, Ga.
7379	Noah Hampton Chiles	1293 Peachtree St., N.E., Atlanta, Ga.
7380	Thomas Albert Collings	1115 E. Rock Springs Rd., N.E., Atlanta, Ga.
7381	Richard Frost Dickinson	Columbus City Hospital, Columbus, Ga.
7382	Grady Ford Duke	Buford, Ga.
7383	William F. Encke	Infirmiry, Univ. of Ga., Athens, Ga.
7384	Walter Thomas Flaherty	1016 Washington St., Michigan City, Indiana
7385	John Orland Ford	Wildwood Sanitarium, Wildwood, Ga.
7386	Catherine Elizabeth Foster	3769 Hamilton Rd., Decatur, Ga.
7387	Noble Owen Fowler, Jr.	Emory University School of Medicine, 69 Butler St., S.E., Atlanta, Ga.
7388	William Vernon Gillikin	Columbus City Hospital, Columbus, Ga.
7389	James A. Hagans	Dept. of Medicine, Univ. of Okla. School of Medicine, Oklahoma City, Okla.
7390	Walter Estes Harrison, Jr.	Moultrie, Ga.
7391	John Marshall Herring	Warm Springs Foundation, Warm Springs, Ga.
7392	James Bryan Hicks	Donalsonville, Ga.
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7394	William Lewis Holder	Box 657, Hollywood, Fla.
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Giant Cell Tumor of the Maxilla in a Young Child

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Athens, Ga.

GIANT CELL tumors are classified in two categories. First, the giant cell epulis or peripheral giant cell tumor and, second, the central or true giant cell tumor. The epulis is a relatively common and frequently seen lesion occurring along the alveolar edges of the jaw, whereas the true giant cell tumor is of relatively infrequent occurrence. The etiology is unknown. Inflammation and trauma have been indicted, but not convicted, as etiologic agents, and more and more the view that this tumor is a true neoplastic growth is gaining credence. Central giant cell tumors involving the maxilla are rare. When seen the frequency is more common in the 20 to 30 year age group, and Geschickter & Copeland estimate that 40 per cent occur in the third decade of life. In reviewing the cases for the past 20 years, medical reports did not reveal another case of extensive maxillary giant cell tumor of the central type in a child as young as six years of age. Interestingly enough, the giant cell tumors of the maxilla seem to be rarely reported by physicians, whereas the dental literature carries numerous reports which are, however, more often concerned with the common epulis, as might be imagined.

Pathologically, the tumor consists of granular masses varying from yellowish to red with a fibrous consistency. Microscopically the tumor is composed of many large multinucleated giant cells imposed on a stroma of round, polygonal, or spindle shaped cells, and many capillaries and new formed blood vessels are of frequent occurrence.

The question of the malignancy of these tumors is often discussed. Some workers (Simmons & Coley) have reported metastasis from these tumors, but Stone and Ewing believe that the giant cell tumor rarely if ever metastasizes and call attention to the fact that no satisfactory record exists of metastasis of a giant cell tumor in its original form. There does seem to be some relationship between osteitis fibrosa cystica and giant cell tumors, but the real correlation is obscure. Probably in the past when a diagnosis of multiple giant cell tumors was made, the

actual disease was osteitis fibrosa cystica, and in some such cases a parathyroid tumor has been found.

Differential diagnosis of a maxillary lesion of this type lies chiefly between this tumor and dentigerous and radicular cysts and adamantinoma. The various sarcomas and osteitis fibrosa cystica also must be considered, and of course carcinoma of the area either primary or secondary must be ruled out. Osteomas should not cause much confusion because of the x-ray appearance, but multiple myeloma and plasmacytoma should be considered. Biopsy is the best method of establishing the diagnosis.

Treatment is by surgery or irradiation, both seeming to offer good results in a considerable number of cases. While in the past it has been suggested that surgery be used and followed by irradiation, the following case suggests that irradiation followed by surgery may be the treatment of choice in certain cases for reasons which will be pointed out in the discussion of the case report.

CASE REPORT

This six year old colored male child was brought to the Athens General Hospital Tumor Clinic, August 22, 1952, with a complaint of swelling in the right side of the face of several months duration. He was first seen by an oncologist who biopsied the lesion. The pathology report on the tissue taken at that time stated that the lesion was a benign epulis. An E.N.T. consultation was requested, and at the first examination of the patient on September 1, 1952, he was found to be a small, unhappy appearing, little fellow with a mass protruding from his right antral region. The mass was smooth, covered with skin, non-tender, hard, and was about the size of a small hen's egg. The right side of the nose was pushed to the left, and the right nasal cavity was occluded; although the nasal mucosa appeared intact. The hard palate on the right side was bulged downward, and a smooth mass protruded between the alveolar ridge and the mucosa of the cheek extending from above the right canine tooth backwards over the first molar. The general physical examination was otherwise negative. X-ray examination of the facial area showed a sclerosis of the superior portion of the right maxilla extending into the zygoma, and a large opaque defect was noted in the right antrum with questionable erosion of the nasal wall and alveolar ridge adjacent. On September 9, 1952, the patient was admitted to the hospital for exploratory surgery. Blood count showed 4.4 million red blood cells, 6,350 white blood cells, 44 seg., 3 juv., 34 lymphs, 19 eosins. Urine showed a trace of sugar but was otherwise negative. The physical findings were unchanged from the previous examination.

The following day under intratracheal gas—oxygen—ether anaesthesia the tumor was exposed through a modified Caldwell-Luc approach. It was found that the mass filled the antrum and extended upward to the infraorbital plate, laterally to the

zygomatic area and medially to the nasal periosteum. The tumor consisted of numerous, encapsulated nodules of a yellowish-white color which were almost cartilaginous in consistency. Because of the extent of the mass and because of the very profuse bleeding encountered, it was not possible to complete the removal of the mass at that time. 500 cc. of whole blood was given I. V. in 250 cc. doses. The surgical findings certainly did not seem to corroborate the previous findings on biopsy of benign epulis, and so large specimens were preserved for microscopic examination. Pathologic examination of the tissue on September 12, 1952, revealed a true giant cell tumor with invasion and destruction of bone, and the pathologist suggested that from the microscopic appearance recurrence was probable.

Since the child's condition did not seem to warrant further surgery at that time, it was decided to utilize a course of x-ray treatments to the tumor. Consequently, during the next three weeks, a total of 3,200 R was given over the tumor area. The patient's condition was then followed for two months. During that time there was a gradual small but definite regression in the size of the mass. The patient's general condition improved somewhat, in that he felt better and began eating well.

By the middle of December 1952, the patient's general condition seemed good enough to warrant further surgical attempt at removal. Admittedly, reoperation was viewed reluctantly because of the severe bleeding encountered at the first procedure. It was only at the insistence of the Surgical Service that another attempt was agreed to, as it was felt that ligation of the common carotid artery on the right would very likely be necessary in order to complete the job. It was strongly felt that unless there was a good chance of completely removing the tumor it was useless to subject the patient to further surgery. The patient was readmitted on January 14, 1953. Two days later the tumor was approached through a right external antrotomy. To the operators' surprise there was practically no bleeding encountered (the right neck had been prepared for ligation of the carotid). The tumor seemed much more encapsulated than at the previous surgery, and it was possible to shell out the tumor without any particular trouble and apparently remove the growth in its entirety. All crypts were then explored and thoroughly cleaned, and two unerupted teeth were removed as they did not seem to be viable. The wound was lightly packed, and the packing brought out through the area of the previous Caldwell-Luc incision which was reopened so that the operated area could be watched during healing. The patient had an uneventful post operative course. Healing progressed rapidly with removal of the packing. Pathologic report on tissue removed again showed true giant cell tumor. Recheck x-ray on February 18, 1953, showed an operative defect of the right maxilla which was smooth and regular with no evidence of any osteitis or infection and no indication of any residual new growth. Follow up examination in March 1954 showed no evidence of recurrence, and the patient was breathing easily through both nasal chambers. Of particular interest from the dental standpoint was the fact that all remaining teeth appeared tight and viable.

Conclusions

It is much too early to draw any sort of conclusions as to what the eventual outcome will be in this

case, and this patient is not reported for the purpose of demonstrating any therapeutic results. Time alone will decide that. The case is reported for two reasons. First, because medical reports fail to show a case of a true giant cell tumor of the maxilla of this extent in so young a patient and second, because it is believed that it would not have been possible to do adequate surgery on this patient without the x-ray therapy he received prior to his second surgical procedure. It is thought that the x-ray treatment was responsible for the decreased bleeding encountered due to occlusion of the vascular stroma. Just as in juvenile fibromas, where it has become a routine procedure to employ x-ray treatment preoperatively, it is believed that surgery of extensive giant cell tumors may be greatly simplified by the utilization of x-ray treatment prior to surgery.

Summary

1. A case of extensive giant cell tumor of central type occurring in the maxilla of a young child is reported.

2. An opinion is expressed concerning the benefit of x-ray used preoperatively in this type of tumor.

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Health in U. S. Best Ever

THE GENERAL HEALTH of the population as a whole was better in 1954 than ever before. Present indications are that the death rate dropped to 9.2 per 1,000 population. This compares with the previous minimum of 9.6 registered in 1953. In fact, 1954 was the seventh successive year in which the death rate remained below 10 per 1,000—a noteworthy record in view of the steady rise in the proportion of older people in our population.

There were about 4,060,000 births during the year, or approximately 90,000 more than the year before, when the previous record high was established. For nine years now the birth rate has exceeded 24 per 1,000 population. The boom in births has added 36¾ million babies to the nation's population within a decade.

(From Statistical Bulletin, Metropolitan Life Insurance Company)

Vein Stripping

IT IS THE purpose of this paper to give a brief resumé of the advancement made in the treatment of varicose veins; the indications, and contraindications for vein stripping; and the operative technic.

The treatment of varicose veins has undergone many changes, particularly in the past 25 years. Years ago extensive surgical procedures were done. Infected wounds, extensive scars, and early recurrences were all too commonly encountered. In the twenties and early thirties, the use of various sclerosing solutions was popular, and this method of treatment replaced most of the surgical procedures. In the late thirties, high ligation of the long saphenous vein with retrograde injections was the method of choice.

The next modification, because of the high incidence of recurrences following this method of treatment, was to add multiple ligations of the perforators to the preliminary high ligation. Subsequent injections were given when necessary.

Again, treatment was modified because of dissatisfaction with the end results. It was found that the communicating branches enlarged and became varicosed, and that veins thrombosed with sclerosing solutions canalized. Also, cases of pulmonary embolism were reported following the injection of sclerosing solutions, and occasional patients developed severe allergic reactions following the injection of these drugs, especially sodium morrhuate. There were valid arguments that these sclerosing solutions entered the deep venous circulation and could be quite harmful.

The most popular and successful method of treating varicose veins, at the present, is high saphenous vein ligation with ligation of all branches at the fossa ovalis, combined with stripping of the vein from the ankle to the groin, together with ligation of the communicating branches by multiple retrograde ligation. The short saphenous vein, if varicosed, is treated likewise.

The symptoms of patients with varicose veins of the legs are directly related to the elevated venous pressure and congestion of the lower extremities when the patient is in a standing position. Primarily these symptoms are a feeling of fullness, a tired heavy feeling of the legs after the patient has been standing, enlarged veins, swelling of the ankles and sometimes severe pain. Symptoms which are due to vari-

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cosities are ordinarily relieved when the patient is not in a standing position unless a skin infection, an ulcer, or some other complication is associated.

Intermittent claudication and cramping pains in the legs are usually associated with peripheral vascular disease. Shooting pains down the posterior thighs are more likely to be related to the spine, as are many of the symptoms associated with the ankles, knees, and feet. The presence of flat feet, arthritis, and other pathologic conditions of the knees, hips, and spine must be noted. Careful pelvic and rectal examinations must be done in order to rule out the presence of tumors or other abnormalities of the lower part of the abdomen and pelvis which may be causing referred pain to the lower extremities.

Many of the failures to relieve symptoms following the treatment of varicosities are the result of failure to take into consideration these many other conditions which can cause a wide variety of symptoms of the lower extremities.

Our first consideration is to detect those cases in which surgical treatment of the varicosities is contraindicated. These cases are rare. There are occasional cases of varicosities following injury which have been associated with phlebitis in which radical surgical treatment is not advisable due to extensive obstruction of the deep venous circulation. The degree and extent of the valvular incompetence must be determined so far as possible. I rarely use the Trendelenburg or Perthes' tests. When a definite history or clinical evidence of deep venous obstruction or peripheral vascular disease is presented, these patients are treated conservatively for a period of time. If symptoms are relieved by properly placed elastic bandages or stockings on the lower extremities up to the knee, there will rarely be any contraindication to the obliteration of superficial varicosities.

In varicosities associated with severe dermatitis or ulceration, surgical treatment should be delayed until the complications have been treated.

The patient is admitted to the hospital the night before operation. The lower extremities are carefully shaved and washed with phisoderm. At operation the lower extremities are draped so that the entire leg is readily accessible to the operative team.

Either low spinal or sodium pentothal is used for anesthesia. A tourniquet is applied just above the knee, and the operating table is placed in slight reverse Trendelenburg position; this procedure makes the vein stand out well. A short, longitudinal inci-

Presented at the 104th Annual Session of the Medical Association of Georgia, Macon, May 2-5, 1954.

sion is then made over the lower end of the long saphenous vein near the medial malleolus. The vein is dissected out; the lower end is ligated with No. 1 catgut. The vein is then severed just above the ligature, and the small end of a Myers' vein stripper of suitable size is introduced into the upper end of the vein and gently pushed up the vein until it meets obstruction either at the medial aspect of the knee or at the fossa ovalis. If it meets obstruction at the knee due to communicating veins, an incision is made over the end of the stripper. The communicating branches are stripped if possible and, if not possible, are doubly ligated. The stripper is then rethreaded into the upper end of the long saphenous vein and pushed upward until it reaches the fossa ovalis.

Then with the olive tip of the stripper for a guide, a transverse incision is made, centering it over the tip of the stripper and extended downward until the stripper is seen; this will be the junction of the long saphenous vein with the femoral vein. All tributaries are individually clamped and ligated, using 00 catgut. There are usually three to five such branches: the superficial iliac circumflex, superficial external pudental, superficial epigastric, and at times, the medial and lateral superficial femoral. However, there are many variations in the venous pattern in the region of the fossa ovalis. It is most important to doubly ligate and resect each branch. If this is not done, these branches will enlarge and act as a by-pass. The internal saphenous vein is then ligated flush with the femoral vein, with 0 chromic catgut, the distal end being transfixed with a suture ligature.

The lower segment of the saphenous vein in the incision near the ankle is securely tied over the phalange of the stripper with braided silk. The stripper is then pulled upward. If a communicating vein is found, resistance will be encountered, and the communicating vein is ligated through a separate skin incision if large, or pulled off if small, and the vein, having been turned inside out, is removed with the stripper from the incision in the groin.

An alternative method is to begin with the dissection and ligation at the fossa ovalis, pass the stripper down the vein, and then strip upwards: in segments, if the stripper meets resistance with a communicating vein at the level of the knee, when the stripper is rethreaded into the distal end of the vein and pushed on downward until it reaches the distal end near the medial malleolus. Frequently, however, the stripper can be maneuvered past the communicating veins all the way to the ankle.

As a vein is stripped, not only are the communicating veins and perforators torn away, but also the sympathetic nerves; this diminishes veno-spasm and thus reduces edema of the affected leg.

If the short saphenous vein is varicosed, it is stripped in a similar manner, by introducing the stripper from an incision near the lateral malleolus and pushing it upwards until it meets resistance at the popliteal fossa. A transverse incision is then made over the end of the stripper and the stripper pulled out, bringing the short saphenous vein with it.

Branches of the long and short saphenous veins, coursing along the leg or thigh either medially, anteriorly, or laterally, are looked for, and when found are cut down on and stripped if possible, and if unable to be threaded with a stripper, are doubly ligated and resected. The Myers' stripper comes in four graduated sizes, and almost any vein prominent enough to be seen easily when a tourniquet is applied above it can be stripped. I have used an Emerson stripper, but find the Myers' stripper more flexible and easier to pass up a vein.

All incisions are packed with dry gauze and left open until the stripping is completed. They are then closed, using 00 plain catgut for the subcutaneous layers and interrupted mattress sutures of silk for the skin. Sterile ABD pads are then placed along the course of the stripped veins and held in place by an three inch elastic bandage, extending from the foot to the groin. The patient is urged to walk as soon as the anesthetic wears off.

The ABD pads are removed the next day, and the elastic bandage should extend only to the knee. Combiotic is given daily for three days. The patient is discharged on the third or fourth day, and should come to the office on the seventh day for removal of the skin sutures. He is instructed to wear the elastic bandage for a month. At the end of that time, his legs are inspected for veins that were missed, and these veins are injected weekly with synasol until thoroughly sclerosed.

Although the results with this procedure have been very satisfactory in my practice and in that of the large clinics, such as Cook County, Mayo, and the Lahey Clinic, another 10 years may be required to thoroughly evaluate this method. In conclusion, it is my opinion that the most effective treatment up to the present time consists of high saphenous vein ligation and ligation of all the tributaries, combined with stripping and multiple retrograde ligation of communicating veins from the fossa ovalis to the ankle.

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The Anginal Syndrome

J. GORDON BARROW, M.D., Atlanta, Ga.

SINCE I CANNOT improve on the classic description of angina given by William Heberden in 1768,¹ and since the treatment of the usual case of this syndrome is well standardized and familiar to most physicians, I would be presumptuous to attempt more than two things in this paper. First, I will try to give a few hints as to how one can go about trying to decide if the atypical case really does have angina, and, second, I will discuss some of the newer forms of therapy which are useful in the case which is resistant to ordinary treatment.

Diagnostic Features

In the difficult or atypical case, the physician must use every hint at his disposal in order to reach a logical conclusion. There are certain predisposing factors to angina, and each of these that is present weighs the balance more heavily in favor of this diagnosis. Age is a factor, since 90 per cent of angina in males occurs over the age of 40.² In females angina is rare under the age of 55 unless other predisposing factors are present.³ The family history should be taken carefully since there is a strong family predilection for angina. A history of diabetes, hypertension, long standing obesity, or hypothyroidism should be suggestive since these all predispose to generalized arteriosclerosis.⁴ The body build of the individual has recently received considerable attention, and the so-called endomesomorph—the short, stocky, bull-necked, barrel chested individual who has hair on his chest and tends to premature greying or baldness—seems to be the individual who frequently develops coronary disease.⁵

The next thing which must be considered is the character and distribution of the pain. The pain of angina is described by patients variously as squeezing, burning, or aching retrosternal pain, or as a weight or oppressed feeling in the chest without pain. Most patients agree that the feeling is very disagreeable, and most have a sensation of impending death during the attack. In contradistinction to other severe forms of pain, such as ureteral or gall-duct colic, the patient feels impelled to stop what he is doing and remain perfectly still. Because of the strangling

nature of the pain the patient will occasionally misinterpret it as dyspnea. It is not uncommon for the patient to try to belch because of the feeling of "gas pressing up." The pain of angina is practically never sticking or knife-like as is the pain in neurocirculatory asthenia. Aside from its typical retrosternal position, the pain may radiate to one or both arms—usually down the inner aspect and into the wrist or the ulnar aspect of the hand. This pain is often described as numbness or weakness of the arms. The jaws and teeth frequently ache, and the pain may be radiated to the neck, back, and occasionally to the epigastrium. Any of these points to which pain may radiate may be the only location of the pain, but, although these unusual locations make the pain harder to interpret, certain of its other characteristics make the diagnosis of angina more tenable. For instance, the duration of the pain and its relationship to exercise. Angina rarely lasts less than one minute or more than five except in cases of angina decubitus when the pain may last from 30 minutes to several hours without clinical evidence of myocardial infarction. It most often has a sharp relationship to exercise, emotion, overeating, or some other factor which increases the work of the heart. Cold is often a precipitating factor as are the arrhythmias such as paroxysmal auricular fibrillation and tachycardia.

An occasional patient will have angina only early in the morning—commonly during or following shaving—suggesting postural hypotension or perhaps a sensitive carotid sinus as a factor. Old people frequently are free of attacks during the day but develop them shortly after going to bed or are awakened by them during the night. One differential point is that patients with neurocirculatory asthenia practically never have pain during sexual intercourse, whereas angina is frequently precipitated by coitus.

A very careful history with painstaking evaluation of these characteristics of the pain and the precipitating factors usually inducing the pain will suffice to make the diagnosis of angina in nearly every case. The physical examination may add little. The presence of hypertension, arteriolosclerosis in the eye-grounds, and peripheral arteriosclerosis should be noted. If valvular disease of the heart is present, it should be remembered that aortic stenosis and aortic

Based on a presentation made at The American Medical Association Clinical Session, Miami, Fla., Dec. 2, 1954.

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insufficiency both predispose to angina, and, if the insufficiency is secondary to syphilitic aortitis, the coronary ostia are often also involved.⁶ Any of the other predisposing factors, such as severe anemia, thyrotoxicosis or myxedema, obesity or familial xanthomatosis, should be noted.

The laboratory aids to the diagnosis are also scanty. The electrocardiogram is unfortunately normal in the great majority of cases, and abnormalities, when present, are often non-specific. When the electrocardiogram is normal and all efforts to reach a clinical diagnosis have failed, the anoxemia or exercise tests devised to bring out latent changes in the electrocardiogram may be used.⁷ These must be evaluated with a great deal of caution since both false negative tests and false positive tests occur with sufficient frequency to make these tests of doubtful value in most cases.

Occasionally the laboratory may be helpful by demonstrating that hypercholesterolemia exists. In the patient whose pain has suggested that hypoglycemia may be a factor, a glucose tolerance curve may be helpful.

The ballistocardiogram has recently received much attention in the diagnosis of coronary disease;⁸ however, its place will have to be settled by long-term follow-up of many thousands of patients. It may be said, however, that a *normal* BCG in a patient suspected of angina is fairly strong evidence against that diagnosis.

Treatment

In the treatment of angina, meticulous attention to detail is necessary. The usual advice of "rest and take a nitroglycerine tablet when you have pain" does not suffice. *Each time* the patient visits you he should be questioned in detail about any attacks of pain since the previous visit. The frequency and duration of the attacks should be noted, and careful evaluation of the precipitating factors should be made. If at all possible, all things which have precipitated attacks should be specifically avoided. If walking has been the offender, a reevaluation of just how far and how fast to walk should be made with the patient. If the attacks always followed a meal, frequent small feedings should be tried. If the attack followed a hot bath, a tepid bath should be ordered for the future. This type of detailed planning with the patient will enable the physician to teach the patient how to avoid almost all, if not all, his anginal seizures.

If this does not suffice, the removal of any possible aggravating factor should be attempted. If the patient is obese, weight reduction is imperative. The omission of all tobacco as a trial is worthwhile. Occasionally gallbladder disease, peptic ulcer, or

hiatus hernia will be a factor; and medical treatment, or if necessary, surgical treatment of the offender is indicated. With properly administered anesthesia, angina does not greatly increase the dangers of surgery. Careful questioning about possible emotional conflicts as a cause of persistent attacks is in order in all stubborn cases.

Every patient should be instructed at length on the proper use of the medicines prescribed. Nitroglycerine, if misused, can be dangerous. I have seen a syndrome of syncope, followed by a shocklike state with peripheral collapse and sweating resembling very closely a silent myocardial infarction, in several patients who used nitroglycerine unwisely. A history was usually obtained of the patient's becoming frightened and taking a nitroglycerine without really feeling pain and then repeating the dose within less than five minutes. Usually a large dose of nitroglycerine such as 1/100 grain was used. It is my opinion that 1/200 or at most 1/150 grain of nitroglycerine is sufficient for most patients. He should be instructed to take the tablet at the first indication of an attack and not wait to see if it will subside spontaneously. The earlier nitroglycerine is taken, the quicker and more successfully it aborts the attack. If the pain is not relieved in five to eight minutes, a second tablet may be taken. If this fails to relieve the pain, no further nitroglycerine should be taken; and the doctor should be notified at once.

The use of alcohol in angina is a much debated question. It has been fairly well proven that the reduction of pain after alcohol is a result, not of coronary dilatation, but of reduced pain perception.⁹ However, in small doses alcohol probably does no harm, and in some cases it may relieve tension. Its danger lies in overindulgence which may result in serious mistakes in judgment by the patient and overwork of the heart.

Peritrate and other long-acting nitrates have value in some cases.¹⁰ In others they are completely ineffective. When large doses of this type drug are being used, faintness and syncope may occur just as with nitroglycerine.

Octyl nitrite like amyl nitrite is taken by inhalation and shares the advantage of being very rapidly effective but also has the disadvantage of uncertainty of dosage administered.¹¹ In general they offer no advantage over nitroglycerine.

In certain types of angina—particularly nocturnal angina—congestive heart failure with intermittent pulmonary edema may be playing a part, and digitalization and mercurial diuretics may effect a complete remission of the angina. Khellin was widely used several years ago, but its use has now almost stopped since the side-effects experienced were unpleasant. Papaverine and the xanthine group of drugs have

been used widely for many years, but there is no proof that either of them really changes the course or frequency of the angina.¹² Quinidine in moderate doses is often quite helpful, particularly when the arrhythmias are a precipitating factor, and sometimes an excellent response is obtained even when arrhythmias have not been evident.

If all drugs fail to relieve the patient, and particularly if the severity and frequency of the attacks is increasing, other types of therapy are available for trial. The use of radioactive iodine to make euthyroid patients slightly hypothyroid occasionally succeeds in slowing the attacks temporarily,¹³ but since myxedema is one of the predisposing factors in arteriosclerosis, it seems that this would not improve the long-term prognosis. Still, if the patient has been made an invalid by his attacks, he is often willing to take this calculated risk. Another even more drastic treatment is the blocking with alcohol¹⁴ or sectioning of the nerve pathways of the cardiac pain.¹⁵ The alcohol injection has the disadvantage of occasional serious post-injection neuritis which in some cases is so painful that a cordotomy is required. The operation, which consists of cervical sympathectomy and stellate ganglionectomy, is usually reserved for those cases in which the physician and patient are ready to accept a calculated risk. Strangely enough, the patient, even though he does not feel the pain any longer, is usually able to sense a vague discomfort when he is having angina, and thus his warning mechanism is not gone after surgery. For many years surgeons have made attempts to improve the coronary circulation surgically. Probably the most successful of these operations has been Dr. Beck's procedure¹⁶ which consists of opening the pericardium, scarifying the epicardium of the ventricles, partially occluding the coronary sinus, and then scattering asbestos within the pericardium. In many cases the results, both immediate and long-term, have been excellent, but the operative mortality is still high since many poor-risk patients are being operated. The operation is being successfully performed in Atlanta, and in other medical centers in the South. It has become a feasible method of treatment in those patients in whom a thorough trial of the medical therapy as outlined above has failed. It should be noted that uncontrolled congestive heart failure, a very large heart, or a recent myocardial in-

farction are contraindications to this type of surgery.

There is one other type of medical treatment in which I place much faith; however, it is unproven in any large series, and for that reason I mention it only as a personal experience. In cases of angina which have progressed to multiple and increasing daily attacks in spite of the usual measures, or in those who have angina decubitus, or so-called coronary insufficiency with attacks coming on at rest and not relieved by nitroglycerine and lasting from 30 minutes to several hours without evidence of myocardial infarction, a period of complete bed rest is tried. If this does not suffice, it is my opinion that dicumarol should be used in doses sufficient to lower the prothrombin to a time equal to the 20 per cent control. This should be continued for three to six weeks, and in most cases the angina will gradually subside. In certain cases of this sort, long-term dicumarol therapy should be used provided out-patient prothrombin concentrations are available. The mechanism of action of this type treatment has not been proven, but since it has been 80 per cent effective on a small series of 30 personal cases, and since when properly used it carries little risk, I believe it should be given a trial before the more drastic forms of therapy are considered.

36 Butler Street, S.E.

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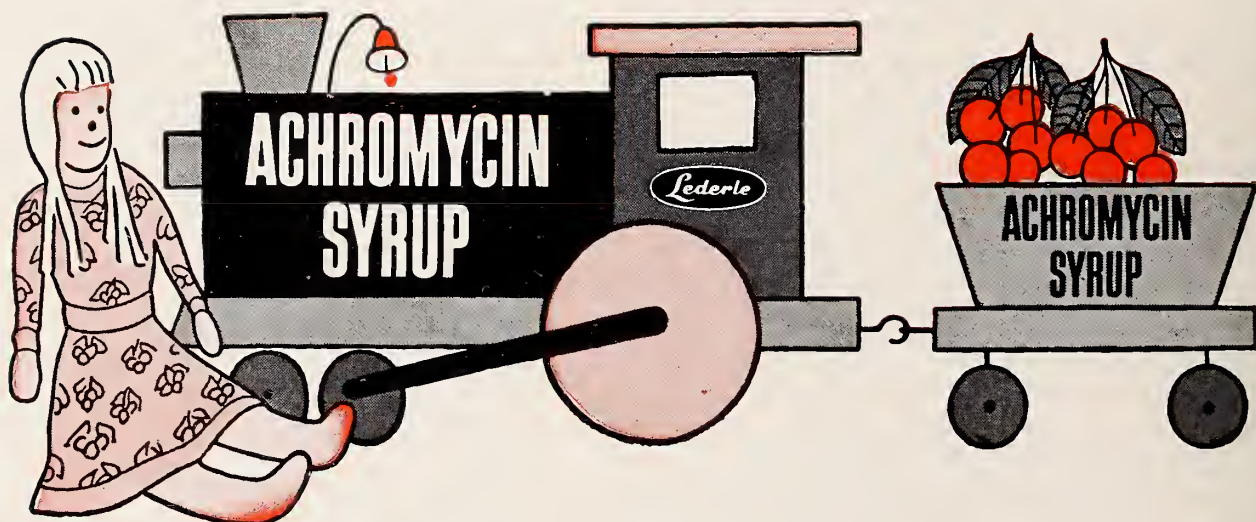
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See page 346

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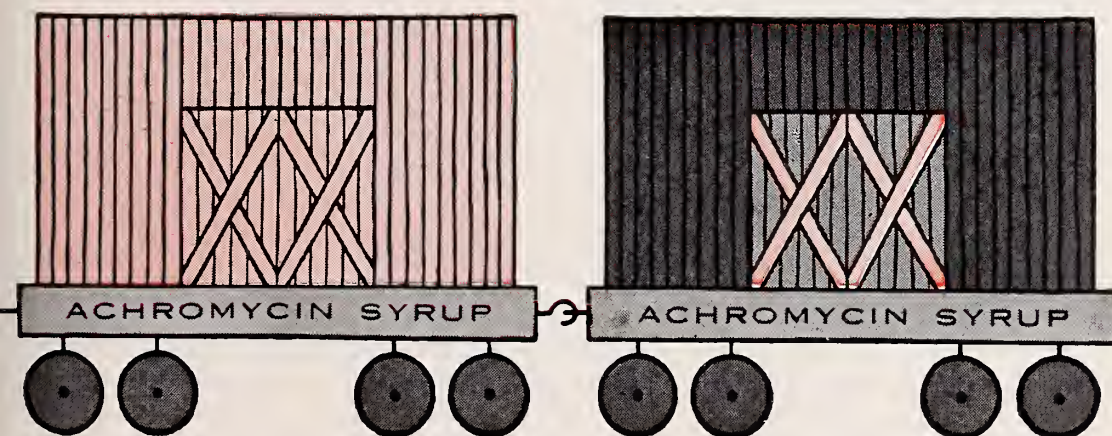
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Rupture of a Dermoid Cyst at the Time of Parturition

CHARLES E. SAX, M.D., Savannah, Ga.

A CASE IS REPORTED here of a rare complication of delivery. No other case of delivery complicated by rupture of a dermoid cyst has been found in the literature. References for the past 10 years have been searched. The patient in the following case presented a problem in differential diagnosis and treatment.

Case Report

The patient was a 27 year old white Para I, Gravida II, who was first seen June 17, 1951. Her last menstrual period was Feb. 20, 1951, and estimated date of confinement November 27, 1951. Past history was non-contributory. Menstrual history normal. Delivery four years previously was full term and uncomplicated. Physical examination and laboratory work were negative except for uterine enlargement consistent with a 15 week pregnancy. No adnexal masses were noted. A few days after her initial visit the patient was seen at home because of pain in her right side. The onset of the pain was several hours prior to examination while patient was visiting out of the city. During the return trip the pain and accompanying nausea had partially subsided. Tenderness in the right lower quadrant was the only positive finding at this time. A diagnosis of subsiding appendicitis was made and the patient kept under close observation. Slight pain persisted for one week. The remainder of the prenatal course was uneventful.

Labor ensued November 19, 1951, and after 6½ hours of uneventful labor a spontaneous delivery of a normal male infant weighing six pounds 15½ ounces was effected. Eighteen hours after delivery, the patient complained of pain in the back of the neck and arms. Thirty hours post partum, the patient was ambulant. Four hours later the abdomen was seen to be distended and this distention rapidly progressed. No intestinal motility could be detected. Temperature was 101°F, abdomen severely distended and tympanitic. Paralytic ileus, with vomiting, was present until the fourth post partum day. This was

treated by the usual methods. She remained distended throughout the course of her illness, although normal evacuation returned. Her temperature spiked daily with peaks of 101° to 102°F. Various diagnostic measures were taken, and she was seen in consultation by Drs. A. J. Kelley and R. B. Gottschalk. Antibiotics failed to control the fever, and she was discharged from the hospital on the eleventh post partum day to be followed at home by Dr. Gottschalk and the author. Nine days later it was felt that an abscess had localized below and to the right of the umbilicus, and she was re-admitted to the hospital.

Laparotomy was performed December 10, 1951, the twenty-first post partum day. The intestines were bound to each other with fibrinous adhesions and involved with the omentum in a large multilocular abscess cavity. There was a large amount of serous fluid and small pockets of pus. The wall of the abscess cavity contained a few strands of hair and appeared to arise from the right ovary. The abscess cavity was explored with blunt dissection, loops of intestine freed along with omentum. A portion of the abscess wall, with an attached mass which was thought to contain the right ovary, was excised. A large cigarette drain was left in the abscess cavity. The pathological report was foreign body granuloma; no ovarian or cyst tissue was found microscopically. The patient's post-operative course was febrile and distention continued. Practically all known antibiotics were used and failed to affect the clinical course.

The patient was re-admitted January 14, 1952, with a diagnosis of subphrenic abscess. She was operated on by Dr. R. B. Gottschalk on January 15, 1952, the sixty-first post partum day. Numerous pockets of pus were opened to the right of the umbilicus beneath the liver, in the left upper quadrant, left pelvis, and the right ovary was located and found to be involved by a dermoid cyst with pus. On opening the ovary, after removal, it was found to contain hair, bones, teeth and skin. Drains were placed and brought out through stab wounds and through the incision. After a rather stormy and febrile course, the patient was discharged January 29, 1952, on the seventy-fifth post partum day.

Presented before the Georgia State Obstetrical and Gynecological Society, Savannah, Oct. 2, 1954.

This patient made a complete recovery after prolonged convalescence and has subsequently gone through a normal pregnancy and delivery. She later volunteered the information that she had been told by one gynecologist in 1950 that she had an ovarian cyst. She consulted a second gynecologist who denied its existence.

It is the opinion of the author that the dermoid cyst ruptured at the time of the delivery.

Discussion

Rupture of ovarian cysts complicating pregnancy is rare. Rupture at the time of delivery has been reported in the literature only a few times. None has been found involving a dermoid cyst. A case similar to the one now described was reported by Vikbladh from Sweden. This, however, involved a large pseudomucinous cystoma. The well known toxicity of dermoid material is here dramatically demonstrated.

Conclusion

The dangers of pregnancy complicated by ovarian cysts are again emphasized. Ovarian cysts should be looked for and removed, if warranted, before or during pregnancy. The differential diagnosis of post-partum fever can be exceedingly difficult.

214 East Gaston Street

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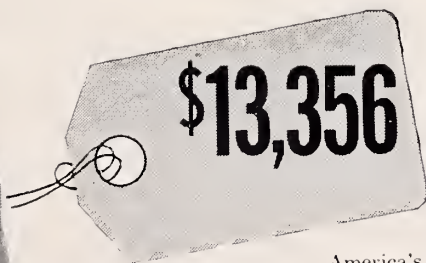
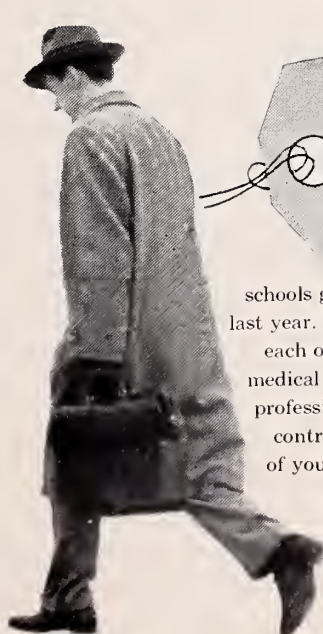
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PREVENT RHEUMATIC FEVER

IT IS BECOMING INCREASINGLY clear that rheumatic fever can be prevented by proper treatment of acute streptococcal infections in the general population, and by adequate prophylaxis against streptococcal infection in rheumatic subjects. The American Heart Association and its affiliates are strongly convinced that rheumatic fever can become a rare disease, and to this end an educational campaign against rheumatic fever is being waged. It is necessary that doctors think of rheumatic fever as a preventable illness and that the public be educated to the fact that proper protection is desirable.

A description of the campaign against Rheumatic Fever appears in this issue on the Heart Page.

PROFESSIONAL LIABILITY INSURANCE

AT THE MAY MEETING of the House of Delegates of the Medical Association of Georgia, a resolution was adopted which empowered the Insurance Board to institute and promote a new type of professional liability insurance in Georgia. Many of the doctors in the state have already been contacted by agents of the Saint Paul-Mercury Indemnity Company. Listen to these men! Your Insurance Board advises you to take the professional liability insurance they offer. It has the endorsement of the Medical Association of Georgia. It would hardly seem fair to advise you to change your insurance without a satisfactory explanation. That is the purpose of this report.

The Insurance Board of the Medical Association of Georgia has made an extensive study of professional liability insurance during the past year. At present most of this insurance is being written by two large companies. Their representatives were first contacted. The agents were very cooperative, but the company representatives failed to give any satisfactory explanation for the large increase in premiums, or what might be done to correct the problem. This was a discouraging start.

Further inquiries revealed that Oklahoma had a type of cooperative insurance program which seemed satisfactory both to the insurance company and the medical profession. Studying this and other programs revealed certain pertinent information:

(1) The number of malpractice claims against the medical profession should be reduced if possible. The present policy of insurance companies' making quick settlements of claims would seem to encourage the making of claims rather than discourage. On the contrary, if a cooperative medical profession backing a strong insurance committee would encourage fighting these malpractice claims, most of them might be won in court. If this were true the increasing tendency to file claims might be discouraged. The experience in Oklahoma has well substantiated this belief.

(2) With fewer malpractice claims and many less settlements, the loss experience should be improved and the insurance premiums accordingly be reduced. In order to be certain of this, members of the medical profession must sit down regularly with insurance company executives and discuss these matters, having access to the complete financial records. No such agreement could be obtained from any of the "Old Line" companies.

(3) A cooperative insurance program presumes doctor participation. Every county society would need an Insurance Committee. Such committees would not only aid the insurance company, but would be available to aid any doctor against whom a professional liability claim had been made.

Your insurance committee has worked out a program keeping in mind the three important principles outlined above. This is quite similar to that which is now operating successfully in Oklahoma. The Saint Paul-Mercury Indemnity Company writes this in Oklahoma, and they have agreed to do likewise in Georgia. This gives us a truly cooperative professional liability insurance program. With our program under way let us keep this in mind. We don't have cheap insurance! Rather, it is the finest insurance obtainable. If the doctors in Georgia work together, we can improve our loss experience and thereby lower the premium. This will be our earned reward. Perhaps even more important, however, will be the efforts to reduce malpractice claims. If successful, this will help maintain the prestige of the profession, a valued possession so frequently under attack in the past two decades.

Again your Insurance Board advises you to carry your professional liability insurance with the Saint Paul-Mercury Indemnity Company. By so doing you will cooperate with our efforts to deal with this increasingly difficult problem.



DIABETES---

THE GREAT IMITATOR

JUST A HALF CENTURY ago modern medicine as we know it today was beginning to come to life. "Syphilis, the Great Imitator" was a well-known axiom of medicine at that time. A patient with diabetes in those days did not live long enough to develop many of the complications of the diabetic of today. In the pre-insulin era the physician confronted with a diabetic generally would throw up his hands and advise the family of the patient that within a year the diabetic would be dead.

Syphilis today has been conquered to a great extent. Our ten-day cures of this disease make the old three-year treatments of pre-war days seem crude and cumbersome, as they were indeed. The treatment of syphilis has been so simplified that we no longer need Alto as a treatment center. With the disappearance of syphilis, diabetes has risen to take its place as The Great Imitator. The diabetic of today, with reasonably good care on his part and under the supervision of his physician, can live a normal, active life and have almost the same life expectancy as a non-diabetic. With the increased longevity of the diabetic, however, we find symptoms and signs similar to other diseases playing a prominent part in the diabetic picture. The extreme nervousness, tremor, weight loss, and general appearance of an acute diabetic onset resembles almost symptom-for-symptom an acute thyroid condition. Diabetic neuropathy may occur without obvious symptoms of diabetes and may cause confusion. Arteriosclerotic changes and peripheral vascular changes due to diabetes may cause some hesitation in making an accurate diagnosis.

In Georgia almost 800,000 people have been surveyed for abnormal glucose tolerance curves. It has been noticed that over the age of 50 the incidence of these abnormal tolerance curves rises sharply. More than seven per cent of those in the 70-year age group were found to have abnormal sugar metabolism.

In view of these facts therefore, we must realize that more and more we are going to be called upon to be on the alert for the presence of diabetes in our patients. Diabetes, the Great Imitator, can affect any and every system of the body, producing symptoms of varied diseases and conditions. To know and understand diabetes well therefore is to know and understand many phases of medicine.

At the meeting of the Medical Association of

Georgia in Augusta, in May of this year, the Georgia Diabetes Association was formed. This association will be affiliated with the American Diabetes Association. The purpose of this new medical group is to promote interest in the study of diabetes, and to help the physicians of Georgia keep up-to-date with modern methods of diagnosis and treatment of this disease. The state association can act as guide and coordinator for lay groups that may be established in cities, towns, and counties throughout the state. Through its affiliation with the national body we can assist in obtaining better nation-wide control of this disease.

A meeting is planned to be held in Atlanta in September of this year. A prominent speaker on diabetes will address the group. This will also serve as the first official scientific meeting of the Georgia Diabetes Association. Any physician interested in the welfare of his patients should realize the importance that diabetes does, and will, play in modern medicine. It behooves all, therefore, to become interested in diabetes, and with this interest, regardless of any other specialty or practice, membership in the Georgia Diabetes Association would seem essential. Any physician interested in becoming a charter member of this organization should sign up before the September meeting. Membership in the American Diabetes Association is not required. Applications for membership in the Georgia Diabetes Association may be sent to any of the following:

Pres., Christopher J. McLoughlin, M.D., 1010 Medical Arts Bldg., Atlanta, Ga.

V.-Pres., George R. Dillinger, M.D., 314 South Broad, Thomasville, Ga.

Sec.-Treas., Alex T. Murphey, M.D., 1719 Walton Way, Augusta, Ga.

THE LAW AND THE PRESCRIPTION PROBLEM

RECENT MODIFICATIONS of the Federal Food, Drug, and Cosmetic Act have pointed out the need for a clearer understanding of the provisions of the sections of the law which deal with the practice of medicine and of pharmacy. A problem of mutual concern to the practicing physician and the pharmacist arises in the refilling of prescriptions. The Federal Law is specific in that a prescription for a dangerous drug may not be refilled without the authorization of the physician. This means that if the patient needs to have his prescription refilled, he must either make an office visit, or the pharmacist must contact the prescriber. Refilling without authorization subjects the pharmacist to a possible one-year jail sentence.

When the pharmacist refuses to refill a prescription, the customer frequently reacts unfavorably toward both the physician and the pharmacist. This misunderstanding could be avoided by indicating on the prescription the number of times it may be refilled, if any. Some drugs, such as narcotics, may not be refilled under any condition and require a new written (not telephoned) prescription. In other cases the physician may not wish the patient to continue the medication and could indicate that it is not to be refilled. Blanks are being printed on which appear numbers that can simply be circled to indicate refills, thus saving the physician and the pharmacist many telephone calls.

The requirement that refill authorization must be given is a sound one and should lead to closer supervision of the patient, if used wisely and if pharmacist and physician cooperate closely. Since the pharmacist must make a written notation of the refill, the physician has available a record of the amount of the drug taken. If a patient is on mild sedation and it is desired to see him every two months, simply write for 25 caps—Sig: one cap three times a day and note to be refilled eight times. Since it is the intent of the law to see that dangerous drugs are used under supervision, there should be no objection if physicians insist on six-month checkups in certain chronic cases by stating “may be refilled at two-week intervals for six months.” Close cooperation between pharmacist and physician will lead to better medical care.

In the past, some chronic patients under the supervision of a physician have been in the habit of securing dangerous drugs such as thyroid or digitalis on prescriptions which may be years old. Inspectors of the Food and Drug Administration are in the process of checking on such cases, and physicians should cooperate by writing new prescriptions and noting whether or not they want them to be refilled. A problem which also confronts the pharmacist is that some physicians simply tell patients to get the refill. Legally, the prescription cannot be refilled without the expressed permission of the prescriber, and the pharmacist is put in the awkward position of questioning the veracity of the customer, if he refuses to refill. Those pharmacists and physicians who have what they call an “understanding” in regard to refills may be called on in court to prove this understanding. Still another problem is that of the “informal” physician who either through ignorance or laziness advises the patient to go to the drug store and buy a drug which has the “prescription only” legend.

Within our own state, convictions have been obtained not only for over-the-counter sale, but for refilling without authorization. Pharmacists and physicians must cooperate in carrying out the spirit and the letter of the law. A little time spent explaining to your patient that the prescription may not be refilled, or that it may be refilled a certain number of times, will save you valuable time later on, and certainly will make for better patient-doctor relations.

Smallpox Still a Major Health Problem

AN OUTBREAK OF SMALLPOX has been reported in the Brittany area of France. Since January 1, at least 73 cases have occurred with 15 deaths. At the present time, following the vaccination of more than one million persons, the disease appears to be under control.

This is an example of what may be expected to happen from time to time as long as smallpox exists anywhere in the world. The United States is by no means immune to episodes of this kind.

In the spring of 1947, a traveler from Mexico City was found to be ill with smallpox upon arrival in New York City. Subsequently, 12 cases of the disease and two deaths occurred. By means of an energetic vaccination program which reached five

million persons in two weeks, the disease was kept under control.

Although the United States has been comparatively free of smallpox during the past decade, the disease continues to be a major public health problem in many areas of the world. As long as that situation exists, it may be expected that the disease will be introduced into this country from time to time. With modern methods of transportation, it is possible for an exposed individual to travel long distances during the incubation period of the disease, and it would be impossible to prevent the occasional entrance of an infected person into this country. If vaccination were neglected for a considerable period of time, each introduction of the infection would be followed by a widespread epidemic.



doctor placement page

NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

AVAILABLE PHYSICIANS

Bell, John Arthur, M.D., 651 East 14th Street, New York 9, N. Y.; Married; Protestant; graduate Cornell University Medical College, 1949; residency II (Cornell) Medical Division, Bellevue Hospital, N. Y. C.; available July 1, 1955.

Campbell, Roy E., M.D., Valley Forge Army Hospital, Phoenixville, Pennsylvania—Age 36; married; Baptist; graduate Emory Medical School, 1943; residency Grady Memorial Hospital, Atlanta; at present in Army will leave in July, 1955; has a Georgia and Florida license; available July 10, 1955.

Chambers, Robert E., M.D., Duke Hospital, Durham, North Carolina—Age 28; married; Christian; graduate Duke University School of Medicine, 1952; residency Duke Hospital; Diplomate National Board; Category IV; specialty Pediatrics; available May 1956.

Ehle, Jack F., M.D., 1600 Asbury Avenue, Winnetka, Illinois—Age 36; married; Protestant; graduate Chicago Medical School, 1946; residency Michael Reese Hospital, Chicago, Illinois; interested in general surgery in clinic or as assistant or associate; available July 1956.

Ferguson, Emmett, Jr., M.D., Duval Medical Center, Jacksonville, Florida—Age 34; married; Baptist; graduate Medical College of Georgia, 1950; 4 years general surgery residency; reserves; interested in general surgery; size of community preferred, 25,000 up; prefers partnership or single practice; available August 1, 1955.

Fletcher, William E., M.D., 3534 Stanford Place, Dayton 6, Ohio—Age 30; married; Protestant; graduate Western Reserve University, 1949; residency Cleveland City Hospital and VA Hospital; 3 years formal training general surgery; 2 year preceptorship general surgery; interested in general surgery in clinic or as an assistant or associate; available July 1956.

Hobart, Seth G., Jr., M.D., University of Virginia Hospital, Charlottesville, Virginia—Age 36; Married; 3 children; Protestant; graduate University of Virginia Medical School, 1950; residency University of Virginia Hospital; 3 years general surgery; 2 years otolaryngology; Board qualified in otolaryngology; Category IV; specialty otolaryngology and major head and neck surgery; available July 1, 1955.

Johnson, B. T., Jr., M.D., 202 South 3rd Street, McGehee, Arkansas—Age 32; married; Baptist; graduate Arkansas Medical School, 1951; presently in practice, desires to relocate; interested in general practice in Georgia in clinic or as an assistant or associate; available immediately.

Mason, Roscoe E., M.D., Surgical Service U. S. Army Hospital, Fort Bragg, North Carolina—Age 32; married; Methodist, graduate Harvard Medical School, 1948; residency Boston City Hospital 13 months remainder including chief residency at Tripler General Hospital (U. S. Army) Oahu, T. H.; expect to be discharged August 1, 1955; available 1-15 August, 1955.

McConnell, Ben H., M.D., Box 664, Beltsville, Maryland—Age 36; married; Episcopal; graduate Georgetown University, 1950; interested in general practice as student health physician with any school, college or university; available at once.

Melcher, Truman O., M.D., ENT Clinic, John Sealy Hospital, Galveston, Texas—Age 41; married; Protestant; graduate University of Texas School of Medicine, 1942; residency John Sealy Hospital; member AMA; specialty otolaryngology and endoscopy; available September 1, 1955.

Rolfes, Harry Franklin, M.D., 1104 N. Shadeview Terrace, Birmingham 9, Alabama—Age 35; married; Catholic; graduate University of Maryland, 1944; has been in resident training, now wishes to locate for first time in ophthalmology; Category IV; prefers clinic; available July 1955.

Roth, Robert Earl, M.D., USVA Hospital, Nashville 5, Tennessee—Age 30; married; Protestant; graduate University of Illinois, 1949; residency VA Hospital, Nashville, Tennessee; specialty radiology; available August 1955.

AVAILABLE LOCATIONS

Arlington, Georgia (Calhoun County)— Population 1,382. In need of doctor-surgeon for practice in new excellently equipped 16-bed hospital, located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia.

Broxton, Georgia (Coffee County)— Population 3,500—Doctors clinic available; also home available; 60 room county hospital at Douglas; seven room doctors building; no physician in area; physician

will have more work than he can do. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia.

Dillard, Georgia (Rabun County)— Population 2,500. Doctor's office to be furnished rent free for one year; would rent five or six room house, fully equipped kitchen, county hospital at Clayton; drug store and pharmacist; good schools; doctor would be welcome right now; late doctor had an excellent practice; other benefits considered in a short time; active church groups and community club that would be happy to assist doctor. Contact: Mrs. L. Neville, Dillard, Georgia.

Edison, Georgia (Calhoun County)— Population 1,245. Two physicians in area; Hill-Burton Hospital (1 mi.); one clinic local with 10 beds, x-ray, lab equipment, operating room with instruments; rental \$75.00 (maximum \$100.00) per month; two excellent drug stores; housing available for rent at \$30-\$40; good elementary and high schools; five churches; great need for a physician in this community. Contact: Dr. J. S. Beard, Edison, Georgia.

Hampton, Georgia (Henry County)— Population 1,000—No doctor in Hampton, nearest 10 miles away; hospital in Griffin; office space, housing available; contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia.

Smithville, Georgia (Lee County)— Population 700—No physician in area; home in Leesburg, office downtown rent free; completely equipped office of two rooms and connecting lavatory with outlets for sterilizers, etc., attached. All Contact: Mr. E. H. Conner, Unadilla, Georgia.

Unadilla, Georgia (Dooly County)— Population 1,200—Dooly County Hospital owned and operated by the people of the county; office space available or will build small clinic and let doctor rent or buy. Housing will be provided rent reasonable or can get house built to suit. They guarantee a good doctor will do well; one physician in area, age 75.

Woodbine, Georgia (Camden County)— Population 1,000. Small, fully equipped office and clinic available; ample office space, delivery room, laboratory (inc. x-ray), nursery, wards, private rooms; five room wooden dwelling adjoins hospital available at \$35.00 mo.; one other doctor in Woodbine, doctor is needed now. Contact: Dr. S. C. Atkinson, Waverley, Ga.

please notify . . .

Medical Association of Georgia
875 West Peachtree Street, N. W.
Atlanta, Georgia

. . . when a location has been filled



MITCHELL COUNTY HOSPITAL

Camilla, Georgia

Originally opened for patients in September 1949 with a capacity of 32 beds, the Mitchell County Hospital has found it necessary to enlarge their capacity by the addition of 18 beds. This addition was completed and put into operation in September 1954. The additional 18 beds provide greater flexibility and improved patient care for the citizens of that area.



KENNESTONE HOSPITAL

Marietta, Georgia

A 50-bed addition to the Kennestone Hospital was dedicated and opened for the reception of patients on April 3, 1955. Kennestone Hospital was originally opened in June 1950 with a capacity of 105 beds. The rapid growth of Marietta and surrounding territory necessitated an addition to Kennestone Hospital.

The Campaign Against Rheumatic Fever

MANUEL N. COOPER, M.D., Atlanta, Ga.

OF HUMAN diseases, the number one killer in the first two decades of life is rheumatic fever. The *exact* cause of this illness is as yet undetermined, but it is well established that streptococcal infection is the first step in the chain of events that leads to the rheumatic state. The susceptibility of the streptococcus to penicillin and the sulfonamides now makes it possible (1) to diminish the incidence of rheumatic fever and (2) to alter the natural history of established rheumatic fever by preventing subsequent attacks, thereby lowering the incidence of valvular heart disease. There is every reason to hope that rheumatic fever can become a rare disease.

The control of rheumatic fever is therefore a problem in preventive medicine, and solution of this problem depends on effective professional and lay education. The purpose of this article is to describe to professional readers the measures being taken to educate the public and to enlist professional cooperation in this education program. Subsequent articles will be devoted to the diagnosis of streptococcal infection and its prophylaxis and treatment.

In February of this year the American Heart Association and its affiliates, in cooperation with the National Heart Institute of the United States Public Health Service, launched the "Stop Rheumatic Fever" campaign. Regional meetings have been held to discuss community participation in this campaign, and that for the southern states was held in Nashville, Tennessee, during March. The Georgia Heart Association will launch an intensive public education program on September 24th.

It is anticipated that all available avenues of presentation will be used to show the American public

how it can "Stop Rheumatic Fever," and such will include newspapers, radio-TV stations, parent-teacher associations, county health departments, ministerial associations, medical forums, county fairs, civic and social club meetings, public libraries, and schools. An educational program on so large a scale will require the enthusiastic services of the medical profession, and especially those primarily interested in heart disease.

Physicians who participate in the public education campaign may obtain materials from the Georgia Heart Association. A good nucleus for a program is a 26-minute film called "The Valiant Heart," which tells how a community rallied to help an eight-year-old boy recover from rheumatic fever. The film provides excellent material on what rheumatic fever is and what happens in a family and in a community when rheumatic fever occurs. A discussion guide for this film is available.

A pamphlet prepared by the American Heart Association called *Now You Can Protect Your Child Against Rheumatic Fever* will be particularly useful to those speaking at public meetings and on radio and television programs. The importance of the "Stop Rheumatic Fever" campaign is graphically presented to parents by two statements appearing in this pamphlet: "If your child has *never* had rheumatic fever—you can help see to it that he does not get it. If your child has *ever* had rheumatic fever—it is important to make sure that he NEVER GETS RHEUMATIC FEVER AGAIN!"

And it is important for physicians, faced with streptococcal infections, to recall that rheumatic fever *can* become a rare disease.

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.



BOOKS RECEIVED

Kohl, Schuyler G., M.D., Dr. P. H., *Perinatal Mortality in New York City, A Study of 955 Deaths*, Harvard University Press, Cambridge, 1955, 112 pp., \$2.50.

Shackelford, Richard T., M.D., *Bickham-Callander Surgery of the Alimentary Tract*, Volumes I, II, and III, W. B. Saunders Company, Philadelphia, 1955, 2575 pp., 1705 illustrations, \$60.00 per set.

J. P. Greenhill, M.D., *Obstetrics, Eleventh Edition*, W. B. Saunders Company, Philadelphia, 1955, 1008 pp., 1170 illustrations, \$14.00.

REVIEWS

Ochsner, Alton, M.D., *SMOKING AND CANCER, A DOCTOR'S REPORT*, Julian Messner, Inc., New York, 1954, 86 pp., \$2.00.

This is a very excellent book as most of Dr. Ochsner's writings are. It is directed toward the lay public and especially the lay public that smokes. Dr. Ochsner points out many statistical facts in regard to the relationship between cancer of the lung and smoking. He scoffs at those people who will not accept this clinical evidence. To quote him in one sentence, "The world might have remained in a sorry plight for many years if British sanitarians had waited for the typhoid germ before accepting clinical and statistical evidence that certain wells in London were the real disease spreaders." The work that he presents in this book is, to our way of thinking, rather conclusive proof of his facts. The main points were:

1. Cancer of the lung is rarely found in non-smokers.
2. Heavy smokers represent a much higher percentage of lung cancer patients than the general population.
3. There is a direct and recognized relationship between the amount smoked and the incidence of cancer.
4. There is a definite increase in the lung cancer death rate in countries where there is a marked increase in tobacco consumption.
5. The increase in lung cancer is greater among men than women. Men frequently are heavier smokers.
6. The incidence of the disease is greater in cities than in the country, corresponding to greater cigarette consumption in metropolitan centers.

7. Most human lung cancers are of a type usually caused by irritants.

8. Similar cancers have been produced on the skin of animals by the application of the condensate from cigarette smoke.

9. Non-smokers who get lung cancers are those exposed to other irritants.

10. Lung cancer among nonsmokers not exposed to other irritants generally is not the epidermoid type that smokers get.

I feel that this book is worthwhile reading both for the medical profession and the lay public and would strongly recommend that every doctor have it in his office.

William A. Hopkins, M.D.

Conn, Howard F., M.D., (Editor), *CURRENT THERAPY 1955, LATEST APPROVED METHODS OF TREATMENT FOR THE PRACTICING PHYSICIAN*, W. B. Saunders Company, Philadelphia, 1955, 692 pp., \$11.00.

This 1955 edition maintains the same high standard as previous editions. Many writers advise a more gentle approach in the treatment of myxoedema than that advocated by Lerman. However, Dr. Lerman does warn against the use of large doses of thyroid extract, if there is evidence of heart disease.

It is helpful that we have some authentic data regarding some of the treatments of snake bites which are enthusiastically believed by the laity. The freezing of snake bitten areas or packing the bitten extremity in ice has become accepted as a very effective treatment by the laity in many sections, and the data furnished in this text illustrating the deleterious effects of these measures will help many practitioners convince his lay friends that such measures are not the answer to the treatment of snakebites. Many physicians in the Southern states, where people are often bitten by rattlesnakes, have come to believe, at least at the present time, that ACTH and cortisone do have a very useful place in the treatment of snakebite.

This valuable book should be in every hospital library and practitioner's office.

Ernest F. Wahl, M.D.

Al Akl, F.M., M.D., *Surgical Technigrams*, McGraw-Hill Book Co., New York, 1954, 346 pp., \$12.00.

With the rapid growth of surgery during the past three decades, a larger number of graduates are receiving training each year. This has resulted in the development and use of many varied methods of teaching in surgical centers; the use of illustrations occupies an important place in this field of instruction.

The author in this neat monograph has collected many drawings illustrating the important steps of 36 of the more common operations. These for the most part fall in the category of general surgery, but there are also a few popular procedures in the special fields of gynecology, urology, proctology and orthopedics. While not of the fancy variety, each illustration shows the important steps of the operation in a way that the student can well understand.

This monograph has a definite place on the "quick reference" shelf of all young surgeons and should be available in all operating rooms as well.

David Henry Poer, M.D.

Netter, Frank H., M. D., Reproductive System, Volume 2, The Ciba Collection of Medical Illustrations, Ciba Pharmaceutical Products, Inc., Summit, N. J., 286 pp., \$13.00.

This volume will fill a place of great importance as a reference of anatomy, physiology and pathology. And also it will be of definite clinical value in aiding the clinician in diagnosis and progress of convalescence. Therapeutic considerations have been obviously omitted except in discussions to clarify the anatomic descriptions.

To know a bit about the artist's background makes the reader appreciate the beauty and accuracy of the illustrations. Frank H. Netter, M.D. graduated from New York University College of Medicine in 1931, and then amalgamated his great talent as an artist with his acquired knowledge as a doctor of medicine. One will quickly be impressed by the comprehensive presentation in the illustrations showing the artist's great knowledge of pathology, anatomy and embryology. But Netter was not satisfied with just the pictorial presentation, he went further to enlist the aid of highly competent men in the specialties of reproductive tracts of the male and female, to give a concise corroboration text paralleling the illustrations.

This volume will be a very valuable adjunct to the "ready reference shelf" of the practicing specialist, of the teacher and of the student. It underscores the old adage, "One picture is worth ten thousand words." It does this with colors, shading, anatomic accuracy, diagrammatic sketches and adequate labeling.

John H. Ridley, M.D.

Yost, Orin Ross, M.D., THE BANE OF DRUG ADDICTION, The Macmillan Company, New York, 1954, 155 pages, \$4.00.

This concise and readable book is a description of the author's 25* years of professional experience with many drug addicts. He also gives citations from recognized authorities on drug addiction.

After a brief introduction in which the author notes the seriousness of drug addiction and its importance to society in general, the discussion of the subject is found in the following eight chapters: 1.

Underlying Causes of Drug Addiction; 2. Ostensible Causes of Drug Addiction; 3. What are the Addicting Drugs?; 4. Who are the Drug Addicts?; 5. Drug User or Drug Addict?; 6. A Typical Drug Addict; 7. Treatment for Drug Addiction; 8. Controlling the Drug Traffic. There is also given a brief glossary of the drug addict's slang jargon. Only three specific references to the literature are given.

The facts and opinions expressed by Dr. Yost conform to those generally accepted by the medical profession. It is recognized that addiction to any of the so-called habit-forming drugs and alcohol is merely a symptom of some basic personality maladjustment. Therefore, the study and treatment of the addict falls within the realm of psychiatry and should consist of more than a comfortable withdrawal of drugs. He emphasizes the importance of the long period of physical and emotional rehabilitation which should be combined with intensive psychotherapy without which successful recovery is almost unknown, and is too infrequent even when all methods of treatment are used to the utmost.

Addiction to some of the opiate derivatives is recognized as the most serious and difficult to treat, but due consideration is given to the evergrowing menace of addiction to the opiate-like synthetic drugs such as Demerol and Methadone and to the various barbiturates. The author gives several case records of each, some in much more detail than is necessary for an impressive example.

This volume would seem to be useful to those seeking accurate and elementary knowledge of the serious problem of drug addiction, to the general practitioner and to the layman as means of public education.

James N. Brawner, Jr., M.D.

Alexander, Harry H., M.D., REACTIONS WITH DRUG THERAPY, W. B. Saunders Company, Philadelphia, 1955, 301 pp.

Drug reactions have become an increasingly important problem in recent years. New drugs are being constantly introduced, and the literature abounds with reports of reactions with drug therapy. The author points out, however, that of all the drugs to which a large segment of the population is exposed only a relatively few have induced reactions. The statement that almost any drug may sensitize man is apparently not borne out by the facts. This book provides an excellent review and appraisal of the reported reactions to drugs. The first part of the book presents a concise description of the mechanisms of drug reactions. The second part deals with the dermatologic and systemic manifestations induced by drugs. Finally the individual drugs, including sedatives, antihistamines, vitamins, organ extracts, local anesthetics, serums and vaccines, drugs used in cardiovascular disorders, anti-infections and

*Deceased January, 1955.

anti-arthritic drugs, and a number of miscellaneous drugs are considered in detail. The book is well-prepared and should prove to be a useful reference text for students and practitioners. Obviously frequent revision will be necessary to include reactions with the newer drugs. Excellent summary tables and bibliographies are presented.

William F. Friedewald, M.D.

Lewis, A.A.G.; M.D., B.S., B.Sc., M.R.C.P., and Wolstenholme, G.E.W.; O.B.E., M.A., M.B., B.Ch., (Editor), **A CIBA FOUNDATION SYMPOSIUM ON THE KIDNEY**, Little, Brown and Company, Boston, 1954, 333 pp., \$6.75.

The practitioner looking for easy assistance in the management of his patients with kidney disease will likely be disappointed by this book for it raises more problems than it answers. The clinical physiologist, however, will value this critical discussion of various aspects of renal function and dysfunction. It is the official transcript of a conference held in London in 1953 under the joint auspices of the Ciba Foundation and the British Renal Association; the participants were recognized authorities from various countries, and a useful feature of the book is the inclusion of stenographic reports of their informal comments. The text is divided into five broad topics:

- (1) Structural and functional relationships in the kidney,
- (2) Tubular functions other than the regulation of acid-base balance,
- (3) Renal share in the regulation of acid-base balance,
- (4) General problems of electrolyte excretion,
- (5) Renal share in volume control of body fluid.

This reviewer is particularly intrigued by Darmady's description of the renal lesions which accompany amino-aciduria; by Wirtz' revolutionary theory concerning the mechanism whereby the mammalian kidney produces hypertonic urine; by the several chapters dealing with the tubular transport of hydrogen, sodium and potassium ions; and by Borst's clinical observations which suggest that circulatory failure reduces sodium excretion by some mechanism which operates independently of changes in the weight of glomerular filtration or the rate of adrenal cortical steroid secretion. The more practical reader will appreciate the discussions dealing with the anuric patient and with the usefulness of aspiration biopsy at the clinical level. This is a good book for the physiologist and the curious internist.

Thomas Findley, M.D.

Kahn, Samuel, M.D., Ph.D., **MAKE INFERIORITIES WORK FOR YOU**, Dynamic Psychological Society Press, Ossining, N. Y., 1954, 184 pp.

On the premises that "It is normal to be abnormal to some degree" and "there are *no* people who are free from inferiorities or superiorities," the author

uses the Adlerian approach to solving major problems of unhappiness. He believes that inferiorities arise early in life and that they are the result of the overemphasis of inferiorities by parents in managing the growing child. Through "overcompensation" superiorities arise. Secondary inferiorities and superiorities may then come into being when one understands the primary states. These secondary conditions are used to take advantage of other people. Inferiorities and superiorities that become intense and produce incapacitating states are called complexes.

As a mode of treatment the preventive phase is considered very important, and the author points out, "As you tell a child he is, so shall he be, for better or worse, if you tell it to him often enough." For those who have complexes developed, there is a list of 40 ways in which inferiority feelings can be handled or overcome. These methods include a number of socializing procedures, hobbies, accentuation of positive ways of thinking, avoidance of negative factors, intellectualizations, and suppressions. Chapters written by Jacob Chodosh, D.D.S., and Arthur Crystal, Pod. D., point out the importance of their specialties and methods of treatment for preventing and overcoming inferiorities. One chapter by W. J. Goldwag, M.D., is directed toward establishing the idea that the length of life is directly proportional to the relative absence of inferiority complexes. A final chapter by the author gives biographies of famous people who have overcome inferiorities. This chapter includes many of the well known personalities of past and modern history.

In general, the book makes interesting reading for laymen and could be used for bibliotherapy in the relatively mild illnesses encountered in outpatient settings.

J. D. Combs, M.D.

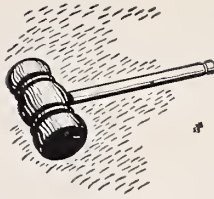
Garland, Joseph, **THE PHYSICIAN AND HIS PRACTICE**, Little, Brown & Company, Boston, 1954, 270 pages, \$5.00.

An excellent book that should be studied by every medical student and young physician before entering practice. For the wife, secretary, and nurse, there is a mine of information.

Starting with a chapter on the evolution of the doctor and ending with Medicine and the Law, everything is included. The various types of practice are discussed: individual, group, general practice, specialty, etc. In this one volume we find such diversified, yet closely related, subjects as the physician's wife, ethics, medical organization, hospitals, office records, insurance program, down to the list and cost of items in his emergency bag.

The book is well written, readable, and well worth the time of any physician, so that he may better evaluate his own practice.

George R. Dillinger, M.D.



MIDSUMMER SEEMS A PROPER time to reflect on education. Never having been privileged to attend nursery school, I can look on this phase of education with objectivity. Some months back I read that a young scholar, age three, was walking to school with book in hand, and, when asked by an elderly friend what he was studying in school, he answered, "Arithmetic." "Then, what is one and one?", to which he replied, "I don't know, I haven't got that far yet."

Having a nursery school student available and knowing that these three-year olds have talents for learning that seems lost on reaching the pupil stage with formal assignments, I decided to investigate this arithmetic that seemed to be south of one. I inquired of my subject, "What is this mathematics you study?". "It is easier shown than explained," he responded and at the same time pulled from his toys an arithmetic set, dumping the contents on the floor. He then proceeded to assemble four equal red segments into an apple, three yellows into a pear and two appropriately colored halves into an orange, with each fitted into its own fossa in a green board. Then he remarked with child-like innocence, "You see there is no confusion in categories up to one."

With this and the subsequent death of Einstein, my memory drifted back to the Englishman George Boole, who invented an algebra upon the equations, one equals everything and one minus anything equals everything else but that anything. As silly as this sounds it has proved of great importance with the invention of calculating machines so that with everything between one and zero cataloging in related categories is simplified to a point of easy mechanization and, of course, mathematical formulation completely taking the tax off memory.

With what X equals not clearly defined and Y being undetermined, all of medicine is wrapped up in the "Standard Nomenclature of Diseases and Operations" with code numbers related to biological units, causes, manifestations, and functions and rubrics, the last two giving X still further use.

A bright student mastering "Standard Nomenclatures, Etc." in the premedical years should get through four years of medical school with only interest and curiosity as a guide. Even with this, a full time salaried teacher of medicine, while quite unessential, should not be put in complete competitive isolation if a fee can be afforded for an offtime consultation.

H. D. Allen, Jr.

MAG Council Meeting

May 29, 1955, Atlanta

THE SECOND MEETING of the 1955-56 Council of the Medical Association of Georgia was called to order at 10:10 a.m., Sunday, May 29, 1955, in the Academy of Medicine, Atlanta, Georgia.

Present were: President-elect, Hal M. Davison, Atlanta; Immediate Past President, Peter B. Wright, Augusta; 1st Vice-President, R. C. McGahee, Augusta; 2nd Vice-President, Stephen W. Brown, Augusta; Secretary-treasurer, David Henry Poer, Atlanta; and *Journal* Editor, Edgar Woody, Jr., Atlanta. AMA Delegates present were: C. H. Richardson, Sr., Macon, and Eustace A. Allen, Atlanta. Councilors present were: Lee Howard, Savannah; George R. Dillinger, Thomasville; W. G. Elliott, Cuthbert; J. W. Chambers, LaGrange; Mark S. Dougherty, Atlanta; Henry H. Tift, Macon; Neal F. Yeomans, Waycross; W. Bruce Schaefer, Toccoa; and, H. L. Cheves, Sr., Union Point. Vice-councilor Ralph W. Fowler, Marietta, represented the 7th District in the absence of D. Lloyd Wood, Dalton. Vice-councilors present were: C. B. Palmer, Covington; Charles T. Brown, Guyton; J. Victor Roule, Augusta; Luther H. Wolff, Columbus; and Charles R. Andrews, Jr., Canton. Association members present in connection with the business of the Council were: B. L. Shackelford, Atlanta; Carl C. Aven, Atlanta; Fred Simonton, Chickamauga; Milford B. Hatcher, Macon; Hubert Milford, Hartwell; and Chris McLoughlin, Atlanta. Also present were the Messrs. Krueger and Kiser of the headquarters office staff.

Council Chairman J. W. Chambers called the meeting to order. Henry Tift, gave the invocation. The first order of business was the adoption of minutes of the 1954-55 final meeting of Council held at the Bon Air Hotel, Augusta, May 1, 1955, and the minutes of the 1955-56 first organizational meeting of Council held at the Bon Air Hotel, Augusta, May 4, 1955. These minutes were approved as read with a correction in the attendance of the May 4 Council meeting—the correction to include Neal F. Yeomans as present.

A report of the 1955 Annual Session was furnished the Council by Executive Secretary Krueger. The financial aspects of the 1955 Annual Session were discussed in detail, and it was reported that the scientific, social, and financial undertakings at the Augusta Annual Session did credit to the Association.

The next item of business concerned a report of the Council Audit and Appropriations Committee by Bruce Schaefer, chairman of this committee. Dr. Schaefer requested that a mimeographed statement, listing the Association budget and the income and expenditures of the Association, be sent to all members of Council quarterly. After some discussion, this request of the chairman of the Audit and Appropriations Committee was approved, and the headquarters office was instructed to mail these statements every three months to all members of Council.

The committee further recommended that the county society minutes book as recommended by the headquarters office for presentation to all county society

secretaries for the recording of meeting minutes be purchased and distributed to each and every county society secretary. The request for this purchase was approved.

The Audit and Appropriations Committee also recommended that "sound equipment" be bought for the headquarters office. The request specifically concerned a dictating machine and a transcribing machine. After some discussion, the request of the Audit and Appropriations Committee for the purchase of sound equipment for use in the headquarters office was approved.

The Audit and Appropriations Committee also recommended the following matters for the information of Council:

1. Increased secretarial aid for the headquarters office as recommended by the Insurance Board, The *Journal*, and the Headquarters Office Travel as approved by the House of Delegates at the 105th Annual Session of the Medical Association of Georgia.

2. The continuance of the Travel Plan for the staff of the headquarters office to visit each and every county medical society.

3. Records and bookkeeping equipment for the headquarters office to streamline the method of membership record recording and financial bookkeeping matters.

4. An additional typewriter and other miscellaneous equipment for the headquarters office as need for such equipment becomes critical.

5. The printing of Georgia Plan booklets for the Insurance Board as the need for these booklets is evidenced in the recent revision of the Georgia Plan.

6. That Council consider in the near future, the need for office furniture in the newly created Council Room in the offices of the Medical Association of Georgia.

The above recommendations were approved by the Council "in principle."

Chairman Chambers then called on Fred Simonton, Chickamauga, to discuss the plans for the 1956 Annual Session. Dr. Simonton reported that on June 19, 1955, the chairmen of the specialty societies participating in the Annual Session would meet in Atlanta for an organizational meeting in their planning of the 1956 Annual Session. Chairman Chambers then called on Secretary Poer who reported that in the main the 1956 Atlanta meeting would follow the outline day by day of the 1955 Augusta Annual Session. It was suggested that better arrangements for the Alumni Dinners be planned, and there was also discussion as to how the President's Banquet might better become the President's Reception to be followed by a dance. At this time Carl C. Aven, Atlanta, was introduced as the Chairman of the Fulton County Local Arrangements Committee. Councilor Mark Dougherty, previously appointed by Council as the representative of the Council for the 1956 Annual Session was then recognized.

The date of the Annual Session was tentatively set for May 13, 1956, and the Biltmore Hotel was suggested. It was moved that the date and the place as tentatively set be approved and the final decision on these items left to the committee. This motion (Brown-Wright) was approved.

Chairman Chambers then called upon R. C. McGahee, Chairman of the Eugene Talmadge Memorial Hospital Committee, to present a report on the committee's activity. Dr. McGahee presented his report together with Dr. Pund's letter of May 27, 1955. Dr. McGahee's report and Dr. Pund's letter are as follows:

**Report of Special Committee Appointed by Council
at the Direction of the House of Delegates to
Present a Resolution to the Board of
Regents Re: The Talmadge Hospital**

R. C. McGahee, Augusta, Chairman

The following is a report to the Council of the Medical Association of Georgia by the special committee appointed to present and explain to the Board of Regents of the University System of Georgia a resolution adopted by the House of Delegates of the Medical Association of Georgia relative to the operational policies of the Eugene Talmadge Memorial Hospital.

"A meeting of your special committee with the Committee on Education of the Board of Regents was held at 10 a.m., May 10, in the offices of the Board of Regents, Atlanta. Present for the special committee were R. C. McGahee, J. G. McDaniel, Stephen W. Brown, David Henry Poer and Mr. John F. Kiser. Present for the Committee on Education of the Board of Regents were the Messrs. Frank Foley, Columbus, Chairman; Charles Bloch, Macon; Edgar Dunlap, Gainesville; H. H. Callaway, Hamilton. Other regents present were the Messrs. Robert Arnold, Roy Harris, David Rice and Everett Williams. Also present were Mr. Harmon Caldwell, Chancellor, Mr. L. R. Siebert, Executive Secretary, and Mr. John Bell, attorney for the Board of Regents.

"Your committee was very well received and we took one hour and 15 minutes of their time which was all we thought necessary.

"A brief of the argument of the special committee had been compiled and each member of the Board of Regents was given a copy at the meeting.

"Many questions were asked by them, mostly to clear up certain points which on the whole were not of a critical nature. Expressions of confidence in the medical profession in Georgia, as well as a desire that the practice of medicine should never become socialized, were expressed.

"It soon became apparent that there was a lack of liaison between the medical profession and the Board of Regents. This had resulted in their not being acquainted with the views of organized medicine. Largely the views and wishes of the Medical College of Georgia had guided them in their proposed policies of operation of the Eugene Talmadge Memorial Hospital.

"One member remarked that all the teaching material necessary for teaching students should be available. Therefore, he favored the admission of patients who could pay for professional services. It was pointed out that illness knows no economic barriers and all types could be found in the indigent.

"Another objection voiced was that only physicians could refer patients and not some agency without medical connection with a physician. It was pointed out that very seldom would such a situation arise, and further that such an agency might abuse its referral privileges.

"The point was made by the Board of Regents that control of the staff was necessary so that proper responsibility and control could be exercised over them. The charge was made that some staff members at present might go for weeks without meeting their classes. This point was readily conceded to by your committee. At the same time it was pointed out that many faithful members of the staff had met their classes, leaving patients in their offices and giving this service without financial reward from the Medical College.

"It was pointed out to the Board of Regents these matters were largely of an administrative nature and could easily be worked out.

"Your committee stressed the point that we were before them on major issue of policy which involved a fundamental principle: that the state not infringe upon the private practice of medicine by taking it over. Certain spheres such as mental disease, tuberculosis, and military personnel of course were excepted.

"No promise was made that they would accept our policy changes requested. They did state that we were not too far apart. Your committee stated very definitely that we had no discretionary power and would have to stand or fall on the one major issue that pay-patients not be eligible for admission.

"At this point we were told that they would have to hear first from Edgar R. Pund. While we were not promised a further conference with the Board of Regents, I feel that the spirit of the meeting was such that further meetings can be had if it is deemed necessary after Dr. Pund's report has been received by the Board of Regents.

"On May 18 a conference with Dr. Pund was held. Present were Thomas Goodwin, Stephen W. Brown, and R. C. McGahee. This conference lasted some one and three quarter hours. At the request of your committee, Dr. Pund set forth in writing his objections to the resolution adopted by the House of Delegates. Dr. Pund expressed regrets that he was not contacted before we went before the Board of Regents. It was agreed that he should have been accorded this courtesy and consideration.

"The same argument was made to Dr. Pund as was made to the Board of Regents. In addition, it was pointed out very forcefully that this issue could result in poor relations between the Medical College of Georgia and organized medicine; that there was too little for the Medical College to gain to risk the harm that could derive as a result of this poor relationship.

"Dr. Pund promised to consider our presentation. He did not promise to change his mind.

"The recommendations of your committee are that we continue our efforts in every way consistent with fairness, equity, and propriety."

Letter from Dr. Pund

May 27, 1955

Dr. R. C. McGahee
1429 Gwinnett Street
Augusta, Georgia

"Dear Dr. McGahee:

"The following comments in reference to the proposed resolutions by the Richmond County Medical Society are sent for your information.

"Paragraph seven of the resolution reads: That the Medical College of Georgia will have a part-time faculty, who will do a major part of the teaching, and also participate in the research program. That the part-time faculty members will not have the privilege of having paid patients in the Hospital.

"I object to this statement because it is a fallacy to think that the major part of the teaching can be done by a part-time faculty, who are earning their livelihood by the practice of medicine. Our experience in the past has demonstrated the many difficulties of such an arrangement, and it will be extremely difficult when the faculty will not only be responsible for teaching medi-

cal students but also for patients' care in the new hospital. I recommend, therefore, that this not be considered.

"Paragraph 10 reads as follows: That only indigent or medically indigent (staff pay) patients shall be admitted to the Eugene Talmadge Memorial Hospital, except in case of an emergency or unusual circumstance, and that no fee for professional services be rendered or collected from patients in this institution.

"My objections to this part of the resolution are as follows:

"1. To admit a patient who is able to pay for his professional service because of any emergency or unusual circumstances, and failure to charge for these professional services would constitute a form of extreme competition with the doctors who are practicing in the State of Georgia, and will provoke innumerable demands on the part of patients to be sent to the State Hospital, where professional services are furnished free.

"2. The determination as to what constitutes an emergency and what constitutes an unusual circumstance will always prove to be a severe administration problem. It would be difficult for a group of doctors to agree on what constitutes an emergency and an unusual circumstance. What one would think was an emergency, others might think that that it was not. If this were allowed to stand, I am quite sure that it would become a constant source of complaint, and, therefore, lead to unnecessary criticism and persistent turmoil between the administration and the doctors of the State of Georgia.

"3. Furthermore, I do not believe that the faculty of the Medical College should be so sequestered that their services could, under no circumstances, be available to anybody in the State of Georgia, when such a need was deemed to exist by the attending physician of the individual patient. In the resolution which has been passed by the Board of Regents, all full pay patients must necessarily be referred by physicians. We must, therefore, defer to the opinion of practicing physicians of the State of Georgia that for a particular patient the services of our faculty are necessary, and we would not deny either the physician or the patient the privilege of access to our faculty who will be in charge of the medical care of the State Hospital. I, therefore, oppose paragraph 10.

"Paragraph 13 reads as follows: That the operation of the Eugene Talmadge Memorial Hospital shall be under the continual observation and counsel of the Board of Regents and its Medical Advisory Committee. This Medical Advisory Committee shall be composed of one member from each of the Medical Societies District of Georgia. Each District Medical Society shall submit to the Board of Regents the names of two of its members, one of which shall be selected by the Board of Regents. This committee shall be a standing committee. Members of the committee shall be appointed for a term of three years or more. The first year the members of the Committee shall be appointed for staggered terms of office.

"The Joint Policy Committee during its meetings had agreed to my recommendation that a Medical Advisory Committee composed of a representative from each District Medical Society should serve in the capacity of a liaison committee, particularly for public relations between the doctors and the Medical College of Georgia.

I would, therefore, favor such a committee, provided it is not conducive to continuation of turmoil. It is my thought, and I feel sure of the policy committee, that such a medical advisory committee would have a local function, rather than be a committee imposed upon the Board of Regents. I do not believe that the Board of Regents should be burdened by such a committee, with the duties as stated in Paragraph 13. I, therefore, recommend that no consideration be given to paragraph 13."

Yours very truly,

EDGAR R. PUND, M.D.

President, Medical College of Georgia

Following Dr. McGahee's report, Stephen W. Brown, member of the special committee, discussed the matter further. Dr. McDaniel, also a member of the committee, emphasized the importance of the Board of Regents' Education Committee with which the special Association committee recently met. Dr. Hatcher, also a member of the Association committee, presented his viewpoint.

On motion (Brown-Elliott) it was recommended that "thank-you" letters be written to (1) the Board of Regents, (2) the Regents' Education Committee, and (3) to Dr. Pund for the cordial reception given the Association's special committee at recent conferences with these groups. The motion also requested that the letter notify these three groups that the special Association committee would be at the disposal of anyone of these groups wishing to meet with it, and the Association committee will continue to function in the interest of the profession. This motion carried unanimously.

On motion (Elliott-Dillinger) it was recommended that an invitation to the Education Committee and Dr. Pund, as president of the Medical College of Georgia, and his executive committee be asked to meet at their convenience with the full Council and the special Association committee at some future date to discuss the matter of the "operational policies of the Eugene Talmadge Memorial Hospital."

After some discussion by Dr. McGahee, Dr. Poer, and Dr. Dillinger, this motion was unanimously approved by Council.

On motion (Richardson-Yeomans) it was recommended that the Council send a vote of "thanks" to the present special Association committee for their splendid efforts in effecting liaison between the Regents' Education Committee, the Board of Regents, and the Association. This motion was unanimously approved by Council.

The next item of business called for the appointment of a Council committee to report on the activities of the Better Health Council so that Council members would be better informed of the Better Health Council's program and planning. Chairman Chambers stated that he would appoint the committee in the very near future. It was moved (Yeomans-Elliott) that the Association continue active support of the Better Health Council in all of its efforts and activities. This motion was unanimously approved by the Council.

The next item of business concerned the June 1955 AMA meeting to be held in Atlantic City. C. H. Richardson and Eustace A. Allen, AMA Delegates, reported on plans for the meeting and asked if the Association had any resolutions to introduce before the AMA House

of Delegates. A resolution introduced by Fred H. Simonton, Chickamauga, at the 105th Annual Session of the Medical Association of Georgia and approved "in principle" by the House of Delegates at that meeting, was then discussed. It was recommended that the MAG Delegates go before the AMA reference committees on this resolution as the same resolution will be introduced by a number of other state associations.

The Council members expressed their heartiest support of the nomination of Eustace A. Allen, Atlanta, for the office of vice-president of the American Medical Association. Dr. Allen will be nominated at this June Atlantic City AMA Session by C. H. Richardson.

The Cline Report on Osteopathy was discussed by both Dr. Richardson and Dr. Allen. After further discussion by Council members, it was recommended that Council await the AMA House of Delegates action on the Cline report before entertaining any motion for action on the Osteopathy Report as submitted by Dr. Cline.

The progress on the professional liability insurance program, as approved by the House of Delegates at the 105th Annual Session, was discussed by Mr. Krueger. Mr. Krueger had recently returned from Oklahoma City where he was instructed in the procedures used by the Oklahoma State Medical Association in administering their professional liability program which is essentially the same as the program approved by the MAG. Mr. Krueger gave a detailed report on the administrative work connected with this professional liability program.

The next item of business concerned the recently elected General Practitioner of the Year for Georgia. C. L. Ayers, of Toccoa, was elected to this honor by the House of Delegates at the 105th Annual Session. After some discussion by Drs. Dougherty and Schaefer, a motion was made (Dougherty-Elliott) that the Association underwrite any expense, not to exceed \$300.00, connected with preparation of material for a presentation of the Georgia GP of the Year nominee for the AMA GP of the Year Award. This motion was approved by Council.

The next item of business concerned a bust of Crawford W. Long and its placement in the capitol building. The Association was asked in a letter from Mrs. Harris, Winder, to approve and endorse this movement. On motion (Schaefer-Yeomans) it was recommended that the Council approve the placement of a bust of Crawford W. Long in the capitol building. The motion passed unanimously.

The next item of business concerned the reserve funds of the Association. On motion (Poer-Tift) it was recommended that a committee of Council be set up to study reserve fund investment and the investment of operational funds on a short-term basis. This motion was approved by the Council. Members of this committee include W. G. Elliott, Chairman; Henry H. Tift and David Henry Poer.

The next item of business concerned naturopathy in Georgia. Mr. Kiser fully discussed the problem and apprised Council of the seriousness of the extent of the problem in connection with naturopathy. This material was presented to Council for information only.

The next item of business concerned a professional conduct problem in Troup County. Chairman of Council Chambers turned the Chair over to George Dillinger, who then presided. J. W. Chambers discussed this

problem and Luther Wolff amplified the discussion. It was then moved and duly seconded that the Council of the Medical Association of Georgia would morally support Troup County Medical Society and actively aid the society, if necessary, in their handling of the aforesaid professional conduct problem. This motion (Davison-Elliott) was unanimously approved by Council.

Dr. Chambers then relieved George Dillinger and again presided at the meeting.

The Council then went into executive session and considered other recommendations made by the Committee on Audit and Appropriations. An increase in salary for one of the headquarters staff was approved. Also it was approved to pay a per diem to headquarters office personnel for extraordinary travel. The question of increasing the salary of the Secretary was then considered and final action deferred until the December meeting to permit further study by the Committee on Audit and Appropriations, and an honorarium to be paid at this time was approved.

Chairman Chambers called for unfinished business. There being no unfinished business, Chairman Chambers then called for new business. It was moved (Yeomans-Elliott) that the Executive Committee be instructed to set the place and the time of the next Council meeting which will be held in September 1955. A vote of appreciation was extended to Dr. and Mrs. J. G. McDaniel for their splendid hospitality to the MAG Council at a social hour and dinner held in the McDaniel residence on Saturday, May 27.

There being no further business the Council adjourned at 2:20 p.m.

MAG Council Meeting

June 7, 1955, Atlanta

AT AN EMERGENCY MEETING of the Medical Association of Georgia Council held in the Academy of Medicine, Atlanta, June 7, 1955, at 11 a.m. the following members were present: President-elect Hal M. Davison, Atlanta; Immediate Past President Peter B. Wright, Augusta; 1st Vice-President R. C. McGahee, Augusta; 2nd Vice-President Stephen W. Brown, Augusta; Secretary-Treasurer David Henry Poer, Atlanta; Councilor Lee Howard, Savannah; Councilor George R. Dillinger, Thomasville; Councilor W. G. Elliott, Cuthbert; Chairman of Council J. W. Chambers, LaGrange; Councilor Mark S. Dougherty, Jr., Atlanta; Councilor Henry H. Tift, Macon; Vice-Councilor Ralph W. Fowler, Marietta (for D. Lloyd Wood, Dalton); Vice-Councilor James M. Hicks, Brunswick (for Neal F. Yeomans, Waycross).

Members of the Association Special Eugene Talmadge Memorial Hospital Policy Committee present were: R. C. McGahee, Augusta; Stephen W. Brown, Augusta; Milford B. Hatcher, Macon, and J. G. McDaniel, Atlanta. Also present was Edgar Woody, Jr., MAG *Journal* Editor, Thomas Goodwin, Augusta, and Executive Secretary Milton D. Krueger.

The meeting was called to order at 11:30 a.m. by Chairman Chambers.

Chairman Chambers asked that the minutes of the regular meeting of Council held Sunday, May 29, 1955, be read only insofar as they pertained to the Council recommendations on the Talmadge Memorial Hospital

policy, and that these minutes not be approved at this time but be accepted for information only. Mr. Krueger then abstracted from the minutes as instructed by Chairman Chambers.

Chairman Chambers then called on R. C. McGahee, Chairman of the Special Association Committee on the Talmadge Memorial Hospital Policy. Dr. McGahee presented the following policy asking for Council's endorsement of the committee's presentation:

Presentation by the Council of the Medical Association of Georgia and the Eugene Talmadge Committee to the Board of Regents Education Committee—Tuesday, June 7, 1955—1:30 p.m.—Atlanta, Ga.

RE: Talmadge Memorial Hospital Operational Policies
"Gentlemen of the Board of Regents, appearing before you today is the Council of the Medical Association of Georgia, its Special Committee on operational policies of the Eugene Talmadge Memorial Hospital and a few additional invited persons.

"At the regular meeting of the Council on May 29, 1955, it was voted to ask the Board of Regents for a joint meeting with their Committee on Education, the President of the Medical College of Georgia and his Executive Committee, and this group from the Medical Association of Georgia. We appreciate your cooperation in arranging for this joint meeting.

"It is the feeling and certainly the hope of the Medical Association of Georgia that, growing out of this joint discussion, the validity of the stand taken by the Association on points of difference might be established. Furthermore, we hope that better liaison relationships and better understanding shall result from this meeting.

"As set forth by our Special Committee in its appearance before you on May 10, 1955, there are only two points of major difference between the Board of Regents and the Medical Association of Georgia concerning the operational policies of the Eugene Talmadge Memorial Hospital. These points concern your proposed policy of admitting pay-patients to the Eugene Talmadge Memorial Hospital and charging for professional services rendered these patients. The other points of difference are of either an academic or of an administrative nature and do not primarily concern the Medical Association of Georgia.

"Our Special Committee on Policy requested of Edgar R. Pund, President of the Medical College of Georgia, his objections to our policy for the operation of this hospital. This letter was to become a part of the report of the Special Committee to Council. The committee had a long conference with Dr. Pund on May 18, 1955, and out of it grew a much better understanding of our views on certain points.

"His objection to that section of paragraph seven of our resolution that a major part of the teaching would be done by the part-time faculty is an academic question, and we readily accept Dr. Pund's objections.

"Paragraph 10 of our resolution reads as follows: 'That only indigents or medically indigent (staff pay) patients shall be admitted to the Eugene Talmadge Memorial Hospital, except in case of an emergency or unusual circumstance, and that no fee for professional services be rendered or collected from patients in this institution.'

"Dr. Pund objects to this paragraph 10 in section 1 and 2 of his communication as follows: '1. To admit

a patient who is able to pay for his professional services because of any emergency or unusual circumstances, and failure to charge for these professional services because of any emergency or unusual circumstances, and failure to charge for these professional services would constitute a form of extreme competition with the doctor who practicing in the State of Georgia, and will provoke innumerable demands on the part of patients to be sent to the State Hospital where professional services are furnished free. 2. The determination as to what constitutes an emergency, and what constitutes an unusual circumstance, will always prove to be a severe administrative problem. It would be difficult for a group of doctors to agree on what constitutes an emergency and an unusual circumstance. What one would think was an emergency, others might think was not. If this were allowed to stand, I am quite sure that it would become a constant source of complaint, and therefore lead to unnecessary criticism and persistent turmoil between the administration and the doctors of the State of Georgia.'

"We do not for a minute doubt the validity of Dr. Pund's reasoning on this point. When we proposed that patients regardless of economic status under emergency or unusual circumstances should be admitted we felt that it was a concession but at the same time a privilege that any person should have granted if the circumstances warranted it on the basis of equity and humanity. If, on the other hand, this provision poses such an administrative problem as to make it unfeasible, we agree to its deletion. It would seem that by admitting only indigent and medically indigent patients that this problem would be solved.

"Before taking up the other provision of paragraph 10 which bears on the major point of difference between us, may we discuss the other point of difference raised by Dr. Pund concerning paragraph 13 which reads as follows: 'That the operation of the Eugene Talmadge Memorial Hospital shall be under the continual observation and counsel of the Board of Regents and its Medical Advisory Committee. This Medical Advisory Committee shall be composed of one member from each of the Medical Society Districts of Georgia. Each District Medical Society shall submit to the Board of Regents the names of two of its members, one of which shall be selected by the Board of Regents. This committee shall be a standing committee. Members of the committee shall be appointed for a term of three years or more. The first year the members of the committee shall be appointed for staggered terms of office.

"The Joint Policy Committee during its meeting had agreed to my recommendation that a Medical Advisory Committee composed of a representative from each District Medical Society should serve in the capacity of a Liaison Committee, particularly for public relations between the doctors and the Medical College of Georgia. I would therefore favor such a committee, provided it is not conducive to continuation of turmoil. It was my thought, and I feel sure of the Policy Committee, that such a Medical Advisory Committee would have a local function, rather than be a committee imposed upon the Board of Regents. I do not believe that the Board of Regents should be burdened by such a committee, with the duties as stated in paragraph 13. I, therefore, recommend that no consideration be given to paragraph 13.'

"It is to be remembered that Dr. Pund himself suggested this committee. There could have been misunderstanding between Dr. Pund and the House of Delegates of the Medical Association of Georgia as to the scope and duties of this committee. It was certainly the understanding of the House of Delegates that it was inclusive in its scope to cover those phases of the operation of this hospital wherein they definitely concerned the practice of medicine in Georgia and not be restricted to 'have a local function' as stated by Dr. Pund. We feel that this committee would be of inestimable value to the Board of Regents and the Medical College of Georgia in building and maintaining good liaison between the constitutional authorities in charge and the medical profession of our state. It is not to be merely a 'watch dog' committee seeking wherein it can find fault and report with the idea of criticism or coercion. We, therefore, feel that this provision of our resolution should remain a part of the policy of operation, with the committee to occupy the lofty station herein outlined.

"Gentlemen, the balance of this presentation of our plea to you concerns paragraph 10 of the resolution of the House of Delegates of the Medical Association of Georgia, passed unanimously on May 3, 1955, concerning the operational policies of the Eugene Talmadge Memorial Hospital.

"This paragraph reads as follows: 'That only indigent or medically indigent (staff pay) patients shall be admitted to the Eugene Talmadge Memorial Hospital except in case of an emergency or unusual circumstances, and that no fee for professional services be rendered or collected from patients in this institution.'

"This paragraph states the only major difference between your proposed policy of operation and ours. While we, as a Special Committee, and the Council as a whole can and do grant you concessions on minor points of difference as outlined in this communication, we have no concessionary rights granted to us on this major issue and therefore will have to stand pleading and contending for it. A fundamental principle is involved which we feel honor bound to preserve. In no sense otherwise do we wish to appear non-conciliatory. In protecting this point we feel that we are protecting the interest of all private industry, yours and ours alike. The Marxist line of approach to Socialism and Communism has always been to take over the control of the practice of medicine first and through this foothold to gradually take over other fields of service and industry. We sincerely hope that the time has not arrived for this creeping, engulfing, and damaging form of Statism or Socialism to find root in our state. Certainly, we, as a Medical Profession, are determined to resist it with all the legitimate force at our command.

"We feel that the primary function of the Medical College is to train students at the undergraduate level, and interns and residents at the post-graduate level, to be able to render the best medical services to our people. In doing this we do not feel that it is the prerogative of the Medical Colleges to infringe upon the domain of the private practice privileges of the medical profession.

"To do so, we feel, is unethical on the part of those physicians who so participate in this infringement. They, we feel, are participating in the corporate practice of medicine, and furthermore, we feel that such practice policies are socialistic in nature.

"Such a policy is unfair to the practicing physicians of our state and unfair to the established hospitals of our state, since they will thus be deprived of a potential source of income by a competing state institution.

"Also, as set forth in our previous argument to you, we feel that it is unnecessary for the state to render this service to those who can pay. Other hospitals with adequate facilities and other physicians with equal skill are available. Let us dissuade the minds of any and all that this is to be a super hospital.

"On the point of availability of the services of staff members of the hospital, Dr. Pund states, 'Furthermore, I do not believe that the faculty of the Medical College should be so sequestered that their services could, under no circumstances, be available to anybody in the State of Georgia, when such a need was deemed to exist by the attending physicians of all individual patients.' If to deny the services of these men to a physician or a patient would mean the deprivation of any essential service not obtainable elsewhere, the medical profession would support the idea wholeheartedly. We of all agencies are primarily concerned with the doctors and patients. But these services can be obtained elsewhere and with equally high standards of proficiency. We feel that the faculty members would be the last to deny the accuracy of this statement. It was not our idea to sequester these men, but on the other hand, it is purely voluntary by those men's choosing to be full-time, and the situation is fostered by the plan of the Medical College and Board of Regents.

"Again, may we also stress the point that these pay-patients are not necessary as a source of teaching material. Disease knows no economic barriers, and any diseases that may be had by the wealthier are more abundantly found in the indigent.

"Doctors have been accused of being selfish and therefore wishing to hold this segment of practice to themselves. We are contending for principles and not dollars. Again, it is a principle that we are upholding.

"Gentlemen, there is another segment of thinking involved in this matter that directly concerns you as the governing body of the University System of Georgia. One division of the system stands to be helped or hurt, strengthened or weakened, in its relationship to the doctors of this state. This is meant in no sense as a threat nor does it imply any idea of concerted retaliation. But, being human as we are, it stands to reason that the profession will feel that its prerogatives have been taken over in part by the state, that its domain has been invaded without reason. Should this occur, that closeness between medical education and medical practice will suffer. Lines are being drawn and sides taken which will hurt the Medical College. On the other hand, if conciliation is granted by you on a point that can mean so little to you, but is fundamental to us, we offer you our warmest support for the Medical College and the Hospital. You stand to lose along with us if we lose on this point. We all stand to gain if you concede to us on this fundamental issue.

"Before and if you decide against us, we respectfully request that you have prepared for you a summary in writing of your thinking and reasoning on this point; study them—both side by side—and then prayerfully decide on this issue."

After some discussion on motion (Dougherty-Dillinger) it was asked that the Council endorse the Special

Committee's presentation and adopt it as Council policy. The Council unanimously approved this motion.

After a general discussion by all members present of the problem, Chairman Chambers entertained a motion for recess. Council members and the Special Association Committee on the Talmadge Memorial Hospital Policies were then to meet with the Regents' Education Committee at 1:15 p.m., at 20 Ivy Street, Atlanta, Georgia. The motion to recess was approved, and it was suggested that, after meeting with the Regents' Education Committee, all Council members and Special Committee members reconvene at the headquarters office.

The Council of the Medical Association of Georgia and the Special Committee on the Talmadge Memorial Hospital policy met with the Regents' Education Committee, June 7, at 1:15 P.M. Chairman of the Special Talmadge Memorial Hospital Policy Committee, R. C. McGahee, read the Council presentation to the Regents' Education Committee and a brief discussion ensued.

Chairman Chambers reconvened the June 7, 1955, emergency meeting of Council at 2 p.m. in the Academy of Medicine, Atlanta.

A general discussion of the Regents' Education Board meeting ensued and the Committee on the Talmadge Memorial Hospital was directed by the Council to act only as Council directs concerning future developments.

A motion was made by all members of the Council to thank the committee for its excellent work on this latest presentation and the Chairman of the Talmadge Hospital Policy Committee then made a motion to thank the Council for the support of his work.

On motion (Dillinger-Howard) it was directed that the June 7 presentation of the Special Committee on the Talmadge Memorial Hospital Policy, as presented to the Board of Regents' Education Committee, be sent to all members with a covering letter to clarify the presentation. It was also advised that some clarification be given on medical indigence. It was also recommended that the mailing should be held for a few days until the final Regents' action is completed and that the covering letter carry information about the action of the Board of Regents in this connection. The motion was approved.

Other items, not on the agenda but discussed very briefly for information only, concerned: (1) state sales tax on services and the question of its involving professional services; (2) short-term investment of Association operating finances, and (3) ophthalmologist and optometrist controversy and Council support of the ophthalmologist.

Chairman Chambers entertained the motion to adjourn. The motion was made and duly approved at 2:20 p.m.

104th Annual Meeting, AMA

June 6-10, 1955, Atlantic City, N. J.

THE 104TH ANNUAL MEETING of the American Medical Association was held in Atlantic City, N. J., June 6-10, 1955. This meeting was attended by more than 12,000 physicians, approximately 80 of them from Georgia.

On Saturday, June 4, the National Medical Civil Defense Conference opened its fourth annual meeting. Its principal speaker was Senator Estes Kefauver. On Sunday, June 5, the conference of presidents and other officers of state medical associations held its eleventh annual meeting. Among the speakers were Senator John W. Bricker, who spoke on the Bricker Amendment, now pending in Congress; Mr. Herbert Philbrick, author of the book *I Led Three Lives*; and James R. Fox of Minneapolis, an American physician who practiced for two years in England; he spoke of his experiences under the British plan of socialized medicine.

The House of Delegates convened on Monday with only a few members absent. One of its first actions was to name the Distinguished Service Award recipient. The Board of Trustees, after considering all applicants, nominated three: Donald G. Balfour, Daniel C. Elkin, and John R. Paul. Dr. Balfour was the winner. I am sorry that our "Dr. Dan" did not win.

There were 75 resolutions on all phases of medical activities presented to the House of Delegates. For a complete report on these resolutions and other activities, see the *Journal of the AMA*. Only a few highlights can be offered here. The Reference Committee on Medical Education and Hospitals presented two reports on Osteopathy. The minority report was adopted by the House. This report still considers Osteopathy a "cult." It stated that if and when the House of Delegates of the Osteopathic Association abandons the so called "osteopathic concept" of disease and requests further discussion with the AMA, then the AMA will be willing to consider the problem at hand.

The Reference Committee on Miscellaneous Business had 10 resolutions dealing with the dispensing of drugs and appliances. None of these resolutions was adopted as presented, but Chapter I, Section VIII, of the *Principles of Medical Ethics* was changed to read, "It is not unethical for a physician to prescribe or supply drugs, remedies, or appliances as long as there is no exploitation of the patient."

The Reference Committee on Medical Education and Hospitals on Internship recommended:

(1) That a continuing study be made as to what should constitute an internship; what constitutes sound clinical experience during the internship year.

(2) That the "one-fourth rule" be adopted; any internship program which in two successive years does not obtain one-fourth of its stated complement be disapproved for intern training.

The same reference committee reporting on hospital accreditation recommended that a special committee be appointed by the Speaker of the House of Delegates to review the functions of the Joint Commission on the Accreditation of Hospitals. This committee is to consist of seven members, none of whom shall be members of the Council on Medical Education and Hospitals or the Joint Commission on the Accreditation of Hospitals. This special committee should be instructed to make an independent study or survey and report its findings and recommendations to the House of Delegates at the next annual meeting. All physicians and hospitals are urged to pass on to this special committee any observations or suggestions concerning the functioning of the Joint Commission on the Accreditation of Hospitals.

As to the polio vaccine, the House of Delegates disapproved the purchase and distribution of the Salk polio

vaccine by any agency of the Federal Government. In the case of those unable to pay for the vaccine, federal funds should be allocated to proper state and county agencies for such purpose. A resolution commending Dr. Salk on his great contribution to medical science was unanimously adopted.

Other resolutions approved were:

(1) Reaffirmation of its previous recommendation that the United States withdraw from the International Labor Organization.

(2) Reaffirmation of its opposition to extension of the Doctor Draft Law.

(3) Warning against the danger embodied in state legislative proposals designed to restrict the entire field of visual care to the profession of optometry.

At the opening session, Walter B. Martin declared that the basic philosophy of medicine has not changed, and "our obligation is to bring the best that medicine can offer to the individual patient." Dr. Hess' opening address stressed that the nation's physicians must become leaders in a campaign to "overcome the ravage of mental illness" as well as in an "intensive campaign to eliminate the needless bloodshed" of traffic accidents.

The inaugural program which was broadcast to the nation by ABC radio network, stressed the theme of "Medicine's Proclamation of Faith." Stirring appeals were made by Dr. Hess and Dr. Norman Vincent Peale to unite medicine and religion for the proper use of our "God given potentials and qualifications."

The final business of the House of Delegates was the election of officers. President: Dwight H. Murray; Vice-president: Millard D. Hill, Raleigh, N. C.; Secretary and General Manager: George Lull; Speaker of the House of Delegates: Vincent Askey, Los Angeles, Cal.; Vice-speaker: Louis Orr, Orlando, Fla. James Rauling was elected to fill the unexpired term of Dr. Murray on the Board. L. A. Larson and T. P. Murdock were reelected to serve on the Board.

The next annual meeting will be held in Chicago; the 1957 annual meeting will be in New York City.

Eustace A. Allen

Maternal and Infant Welfare Committee Meeting

May 1, 1955, Atlanta

THE MATERNAL AND INFANT Welfare Committee met May 1, 1955 at the Bon Air Hotel, Augusta, with Dr. Frederick H. Falls, President of the American Committee on Maternal Welfare, Inc. as a special guest. Committee members present included Doctors Hydrick, Bellhouse, H. Griffin, and C. Mulherin. Sub-committee members J. L. Walker and Albert Kelley were present, as was Mr. Bradley Wells, statistician, also an invited participant.

The meeting was a supper meeting and lasted about four hours. Chairman Hydrick presided. Routine business included a report by Dr. Hydrick on committee members' response in reviewing completed questionnaires and completion of the brief one-page protocol on each. This led into a discussion of a proposed new format for the questionnaire prepared by Mr. Bradley Wells as a result of the discussion at the previous meeting. It was felt that more background information was

necessary and a more logical sequence. It was recognized that the new form could eliminate a great deal of clerical time spent in anonymization before review.

The need for committee knowledge of public health resources in each county where a death occurred was pointed up by one physician who, in reporting on a maternal death, expressed strong feelings about the lack of public health prenatal care because of lack of established M.C.H. clinics. In reality, although there is only one public health nurse in this country where there should be three, there is a monthly clinic for prenatals, postpartals and infants with a doctor in attendance.

Dr. Mulherin reported briefly for the information of the committee and guests on the two statewide multi-professional meetings held in the last year to review and plan for meeting the rural obstetric and infant needs. Dr. Mulherin felt, particularly since a steering committee was to be appointed to direct the recommendations to the proper responsible groups, and to implement action, that these two meetings were a "forward step." Dr. Mulherin had represented both this committee and the Georgia Obstetrical and Gynecological Society at these meetings and had been active in presenting a resolution for Medical Association action. Dr. McPherson also had represented the pediatric component of the committee and had been active in preparing said resolution.

Following this, Dr. Falls reviewed the organization and activities of Maternal Welfare Committees in several other states, and of the American Committee on Maternal Welfare, Inc. The latter is very similar in composition to the groups which had been organized in Georgia for the two meetings reported on by Dr. Mulherin, and the latter information should be referred to their steering committee.

Dr. Falls presented an outline of suggested procedure for organization and activity of a maternal and infant welfare committee.

In regard to the operation of our Maternal and Infant Welfare Committee, several basic questions were asked of Dr. Falls and free discussion followed.

First, The item of how best to function in regard to obtaining information on maternal deaths. Obviously the ideal way is personal contact. In Georgia the problem of distances, lack of professional personnel, and need for privacy and intimacy were recognized. In general Dr. Falls reminded us that a person qualified professionally must also be personally qualified or trouble will arise. The committee recommended that the State Health Department make every effort to locate such a person for employment in the M.C.H. Division.

There was then discussion of how the medical schools could, and should be, of assistance, although there was only unofficial representation of the medical schools, Doctors Griffin and Mulherin. It was Dr. Falls' feeling and the feeling of the group that both schools would have to give help, and that perhaps working with the State Health Department something could be worked out if the proper person could be found. In the meantime it was agreed the questionnaire, anonymized, can be most useful particularly if the committee carries out its plan of a summary review of the work done by individuals, by the group and preparation of a written report pointing out preventable factors and needs. Blood Banks and autopsies were discussed. Dr. Falls advo-

cates the anonymization procedure under any circumstances. If there is personal investigation only the investigators making the report should know the names and locations involved.

A verbal report to the State Obstetric and Gynecological Society and to the Academy of General Practitioners is made annually in some places. The committee agreed that this was a good idea and, although it was not discussed, it was apparent that an attempt should be made to include such reports on the programs of both groups. When more work has been done by the pediatric section of the committee it, too, could report to the Georgia Pediatric Society.

Dr. Falls urged that committee and sub-committee members continue to expand participation in county and district society meetings. He also urged utilization of audio-visual materials and told of how in one state the physician member of the M.C.H. staff visited the medical schools taking such exhibits and spending several days with them as well as participating in organized class and group discussion work.

Since there has been discussion in the past of the

advisability of setting up a different committee to review the infant death problem. Dr. Falls responded to our question by saying that the perinatal period which terminates at the 28th day of life is a common area of interest and responsibility for both pediatrics and obstetrics. In some states the committee as a whole meets, and there are additional separate meetings on the infant and maternal problems, with reports back to the entire group. It was agreed that that procedure may help us. Beyond the neonatal age is another problem and would require another committee.

In Illinois protocols of all deaths are sent ahead to each committee member. One person makes up the protocols. The cases are then taken up for discussion, one by one, then there is a vote as to preventability factors. The Illinois committee averages four or five meetings a year which last seven hours or longer. A letter is written back to the physician, if he so desires, pointing out the preventable factors.

The committee reviewed its approval of the Daytona Beach Obstetric and Pediatric Seminar dates for this year, September 12, 13, and 14.

New Social Security Law Enacted

PHYSICIANS, HOSPITALS, AND CLINICS will have an important part in assisting their patients to get the benefit of a new provision of the social security law which protects a worker's social security record while he is disabled.

A person who is unable to work because of mental or physical disability, or who is blind, can have his social security earnings record "frozen" under the new law.

The effect of this action is similar to that of the waiver of premium in life insurance policies. It provides that the benefit payable to the person when he qualified, or to his family in case of his death, will not be reduced because of the period in which he had no earnings.

Persons already receiving monthly old-age insurance benefits, if they were disabled for a considerable period of time before they reached 65, may have their benefits increased under the new law beginning with payments for July 1955..

The new law protects the social security records of people

- who have been in work covered by social security for five out of the 10 years before they were disabled, and for one and one-half out of the three years before they were disabled;
- who are unable to engage in substantial gainful

activity because of a medically determinable impairment which is expected to be of long-continued or indefinite duration; and

- who apply to have their records frozen while they are disabled and after they have been disabled six months or more.

A determination that a person is disabled must be based upon medical evidence. The patient himself is expected to secure the initial medical evidence; therefore he will frequently request a summary of the history, clinical findings, and treatment of his case from his physician or medical facility. In other cases the request, along with a release signed by the patient, may come from the state agency responsible for the determination of disability, or from the Social Security Administration.

The medical reports will advance the patient's welfare if they are completed promptly and accurately, with sufficient detail to support the diagnosis.

The Social Security Administration hopes that many applicants can be returned to productive work through vocational rehabilitation services. Work in connection with rehabilitation services or in a "sheltered workshop" will not prevent a finding of current disability.

Further information regarding the new freeze provision is available from your nearest social security office.

ANNOUNCEMENTS

American Institute of Dental Medicine—Desert Inn, Palm Springs, Cal., October 23 to 27, 1955. Faculty will consist of Maury Massler, D.D.S., M.S., Chicago; Valy Menkin, M.D., Philadelphia; Hans Selye, M.D., Montreal; Reidar F. Sognnaes, D.M.D., Ph.D., Boston; and Wendell L. Wylei, D.D.S., San Francisco. Applications and full information may be secured from the Executive Secretary, Miss Marion G. Lewis, 2240 Channing Way, Berkeley 4, Cal.

Annual Convention of the National Society for Crippled Children and Adults—Palmer House, Chicago, November 28-30, 1955. Convention sessions will include speeches, institutes, seminars, workshops, round table discussions, and demonstrations by experts in the rehabilitation field. For information write to the National Society for Crippled Children and Adults, 11 South LaSalle Street, Chicago 3, Illinois.

American Dermatological Association, Inc. Annual Prize Essay Contest—Cash prizes (4) will be awarded for the best essays submitted as original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. Manuscripts (in triplicate) must be submitted not later than November 15, 1955. Further information may be obtained by writing to the Secretary of the American Dermatological Association.

Gulf Coast Clinical Society Annual Meeting—Pensacola, Fla., October 27 and 28, 1955. For further information write to Dr. Barkley Beidleman, Secretary-Treasurer, Gulf Coast Clinical Society, 1750 North Palafox Street, Pensacola, Fla.

Academy of Psychosomatic Medicine Second Annual Meeting—Hotel Plaza, New York City, October 6-8, 1955. General subject is "The Psychosomatic Aspects of Drug Administration." Those who wish to present papers at this meeting, are invited to communicate with the program chairman, Dr. Ethan Allan Brown, 75 Bay State Road, Boston 15, Mass. from whom applications for Fellowship and copies of the Constitution may also be obtained.

American Congress of Physical Medicine and Rehabilitation 33rd Annual Session—Hotel Statler, Detroit, August 28-September 2, 1955. Full information may be obtained by writing to the Executive Secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

The Georgia Diabetes Association was organized May 2, 1955, during the Annual Session of the Medical Association of Georgia. This organization is designed to stimulate interest in diabetes among the physicians of this state.

Plans are being made to organize subsidiary lay groups. Through these agencies a program of public education will be fostered with particular emphasis on education of the diabetic in the care of his disease. Such a group has been active in Atlanta for some time.

The Georgia Diabetes Association will guide these lay groups, furnish speakers to medical societies on request, and offer all possible help in the diagnosis and treatment of diabetes. Plans for an active research program are being considered.

At the first meeting officers were elected. Christopher McLoughlin, Atlanta, is president; George R. Dillinger, Thomasville, vice-president, and Alex T. Murphey, Augusta, secretary-treasurer.

The next meeting will be held in Atlanta in September. At that time a constitution will be established and plans made for obtaining a suitable visiting speaker for the next MAG Annual Session. Problems of organizing local lay groups will be discussed. Guy H. Adams, C. R. Arp, and E. Van Buren of Atlanta are in charge of arrangements for this meeting.

All physicians interested in diabetes are cordially invited to join. Dues are four dollars (\$4.00) per year. Checks should be made out to The Georgia Diabetes Association and mailed to:

Dr. Alex T. Murphey, Secretary-Treasurer
Georgia Diabetes Association
1132 Druid Park Ave.
Augusta, Georgia

All joining prior to the September meeting will be classified as charter members.

It is sincerely hoped that the enthusiasm in this society will continue. Care of the diabetic always presents problems, and this organization hopes to offer some help to Georgia physicians in solving them.

Post Graduate Course in Pediatric Allergy—New York Medical College, Flower and Fifth Avenue Hospitals, each Wednesday, November 2, 1955, through May 31, 1956. Applicants must be certified in pediatrics or have the requirements for certification. Enrollment limited, fee \$300.00. Research fellowship in Pediatric Allergy available. Apply: Office of the Dean, New York Medical College, Fifth Avenue at 106th Street, New York 29, N. Y.

Directory—"Cancer Services and Facilities in the United States, 1954"—Compiled by the National Cancer Institute, can be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for 45 cents a copy.

Tennessee Valley Medical Assembly—Read House, Chattanooga, Tenn., October 3 and 4, 1955. This meeting is sponsored by the Chattanooga and Hamilton County Medical Society and will have approximately 16 nationally known guest speakers. For reservations write to: Chattanooga, Inc., 819 Broad Street, Chattanooga, Tenn.

Eight Week Comprehensive Course in Industrial Medicine—beginning September 26, 1955, Post-Graduate Medical School of New York University-Bellevue Medical Center, New York City. Among the subjects offered are: organization, administration and economics of an industrial medical department; the practice of preventive and constructive medicine in industry; the clinical aspects of occupational diseases; industrial injuries and the elements of safety programs; and toxicology and industrial hygiene for the physician. Applications should be sent to the Dean, NYU Post-Graduate Medical School, New York 16, N. Y. Tuition \$250.00.

Annual Assembly in Otolaryngology of the Department of Otolaryngology of the University of Illinois College of Medicine—Chicago, September 19 through October 1, 1955. Registration is optional for one or both weeks. For further information write to Dr. Francis L. Lederer, Dept. of Otolaryngology, University of Illinois, College of Medicine, 1953 West Polk St., Chicago 12, Ill.

DEATHS

JOSEPH SIDNEY BEARD, Edison, died at his home on June 2, 1955. He was 75 years old and had practiced in Edison for 45 years.

Dr. Beard was born in Clay County, February 8, 1880, son of the late Martha Barfield Beard and W. L. Beard. He was a member of the Edison Methodist Church, serving on its board of stewards for many years. He was a Mason, an Odd Fellow, and a member of the Southwest Georgia Medical Society.

Funeral services were held for Dr. Beard on June 2nd in the Edison Methodist Church; burial followed in the Salem Cemetery. Members of the Southwest Georgia Medical Society were honorary pallbearers.

Survivors include his wife, the former Miss Annie Miller; a stepson, C. L. Cunningham, of Charlotte, N. C.; and three sisters.

CLAIR ABIE HENDERSON, Savannah, died as a result of injuries received in an automobile accident on May 15, 1955, in Pensacola, Florida. He and Mrs. Henderson, who was slightly injured, were returning to Savannah from a meeting in New Orleans.

Dr. Henderson, a native of Sycamore, was in his 52nd year at the time of his death. He graduated from the Medical College of Georgia in 1935 and did graduate work in public health at the University of North Carolina, and he had been Chatham County Health Commissioner in Savannah since 1943.

He was a member of the Rotary Club and the Methodist Church.

Survivors, beside his wife, include two sons, Al and Ed Henderson, Savannah; his mother, Mrs. C. A. Henderson, Sycamore; and one sister, Mrs. W. M. Goodman, of Poulan.

SOCIETIES

The CHEROKEE-PICKENS MEDICAL SOCIETY met at the Pinecrest Inn in Canton on May 27 to enjoy a steak supper. Dr. Schmidt of Marietta spoke on the "Treatment of Urinary Tract Infections."

The FULTON COUNTY MEDICAL SOCIETY held its June meeting on the 2nd of the month at the Academy of Medicine, Atlanta. At this meeting the society approved plans for an Industrial Health Council of Greater Atlanta, which will next fall sponsor widespread screenings of workers for health purposes. The council is a nonprofit organization made up of representatives from management, labor, and the professions. Plans are to conduct screening tests in businesses and plants which choose to cooperate. The society also approved a resolution calling for the formation of an Atlanta Orthopedic Society.

The regular meeting of the HALL COUNTY MEDICAL SOCIETY was held on Tuesday, May 10, 1955, at the Wheeler Hotel in Gainesville. Walter Sheldon, pathologist at Emory University, gave a talk on "Recent Advances in Biopsy Techniques." This is the last meeting of the society until September.

NEWTON COUNTY MEDICAL SOCIETY held a dinner meeting on May 17, 1955, at the Newton County Hospital. The film "All My Babies" was shown to the members and the members of the auxiliary.

The THOMAS COUNTY MEDICAL SOCIETY held its quarterly meeting on June 16, 1955, at the Archbold Memorial Hospital, in Thomasville. FRANK D. MULLINS, JR., Augusta, read a paper on "The Use of Papanicolaou Methods in Cancer Detection," and W. STEWART FLANAGAN, Augusta, read a paper on "Management of Injuries and Deformities in the Mid-face." The scientific meeting followed a social hour and dinner.

The WARE COUNTY MEDICAL SOCIETY met on June 2, 1955, at the Okefenokee Golf Club, Waycross. H. A. Seaman and J. F. Hooker were hosts for the meeting.

PERSONALS

First District

T. S. McGowan, Savannah, chief of surgery at the U. S. Public Health Service Hospital in Savannah for the past two years, has been reassigned to the Coast Guard Academy at New London, Conn., where he will be senior medical officer.

DAVID ROBINSON, Savannah, has been elected president of the Armstrong College Alumni Association. He is a graduate of Armstrong in the class of 1937. He served as vice-president of the alumni last year and as membership chairman the preceding year. As membership chairman he was awarded one of the first three "Gold A's" offered.

THOMAS ROSS, JR., Savannah, past president of the Georgia Heart Association and a member of the national board, was the principal speaker at the annual meeting of the First District Chapter of the Heart Association on May 31, 1955. Dr. Ross outlined the program to stop rheumatic fever which will be launched full scale this fall. (*see the Heart Page*).

IRVING VICTOR, Savannah, has been elected to the Board of Trustees of Armstrong College.

DAN H. WILLOUGHBY, Savannah, has been appointed director of the Tuberculosis Hospital in Savannah. He will continue his private practice, however, since supervision of the hospital will require only part of his time. A native of McComb, Mississippi, Dr. Willoughby is a graduate of Duke University School of Medicine. He served his internship at Vanderbilt Hospital and took specialized training in internal medicine there. Since 1953 Dr. Willoughby has been associated with ELLISON R. COOK, III, in the practice of internal medicine.

Second District

M. B. BOWMAN, Albany, has been named a qualified fellow in the International College of Surgeons.

A "Children's Memorial Fund" has been established

(Personals)

at the Phoebe Putney Hospital in Albany in memory of the late LILLIAN INGRAM who died in 1954. Dr. Graham, a well known pediatrician in Albany, named the hospital beneficiary of a \$2,500 insurance policy, and this money is being used as a nucleus for the fund.

Third District

BON DURHAM, Americus, was reelected surgeon at a district meeting of Veterans of Foreign Wars held on May 22 in Dawson.

Lewis Lamar Hatcher, formerly of Milledgeville, has opened offices for the general practice of medicine in Dawson. A native of Dublin, Dr. Hatcher received his B.S. degree from the University of Georgia and his M.D. degree from the Medical College of Georgia. He interned at Milledgeville State Hospital before entering practice for himself.

R. C. PENDERGRASS, Americus, addressed the Vienna Lions Club Ladies Night meeting on May 23. Dr. Pendergrass said that cancer killed more people in the United States last year than were killed in three years of the Korean War, and he pointed out that Americans spend billions more each year for cosmetics, liquor, amusements, and other non-essentials than they do in the fight to conquer this dread killer.

CHARLES SMITH, Columbus, addressed the clinic for adult development at the Wynnton Methodist Church. His topic was "Personality Adjustment." His talk dealt mainly with emotional feelings and adjustments necessary as persons grow older.

HERSCHEL SMITH, Americus, and Mrs. Smith were hosts at their home at a party in May for the personnel of the Americus and Sumter County Hospital, the hospital authority, nurses and doctors, and the medical staff and their wives. About 175 guests called between the hours of 8:00 and 10:30 o'clock.

R. E. Tiller and Mary John Tiller have recently moved to Columbus to practice medicine. The former will practice privately and the latter will be associated with the Health Department.

Fourth District

FLOYD E. BATES, Chipley, opened his up-to-date clinic on the main street of Chipley on February 24, 1955, and now the clinic has been licensed as a two-bed hospital, according to an announcement of the State Licensing Board.

HARRY KING, Griffin, was manager of the doctors' team when they played the nurses of the Griffin-Spalding County Hospital in a benefit game on June 1, 1955. The game was sponsored by the Hospital Auxiliary, and all proceeds are to be used to equip a recovery room at the hospital. Players on the doctors' team were JACK AUSTIN, GEORGE HENRY, JOHN CLOUSE, TOM HOPKINS, WILLIAM KING, H. J. COPLAND, J. R. THOMAS, STEWART FITZHUGH, GRADY BLACK, TOFEY SMAHA, OTIS BUTLER, HARRY KING, KENNETH HUNT, JOEL COX ABE OSHLAG, HENRY GOULD, GUS FRYE, BOB FOSTER, KIRBY STARR, ALEX JONES, WRIGHT HICKS, GEORGE BROWN, and JIM HOWELL.

H. D. TYLER and T. A. SAPPINGTON, Thomaston, will share facilities in a building now under construction

in Thomaston. The building will be a brick and masonry, one-story structure of "somewhat modern design." Individual entrances and separate waiting rooms will be provided for the two physicians to share the building. Offices will be on either side of the building with laboratory and other utility rooms in the center.

Fifth District

CARL C. AVEN, Atlanta, was elected Historian of the American College of Chest Physicians for 1955-56, at the 21st annual meeting of the college held in Atlantic City, June 1-5, 1955.

Stuart G. Blackshear, Atlanta, has received a fellowship appointment in surgery at the Lahey Clinic in Boston. Dr. Blackshear has been serving his residency in surgery at Grady Memorial Hospital, Atlanta, since his return from Korea in 1952.

EDGAR BOLING, Atlanta, has been notified of his election as a fellow of the American Proctologic Society in New York on June 5.

WILLIAM F. FRIEDEWALD, Atlanta, addressed a recent meeting of the Griffin Kiwanis Club on the effectiveness of the new Salk polio vaccine. He stated that he believed that it is too late to do much about providing immunization against polio for this summer, and that medical authorities should concentrate on a fall program for giving polio shots. Dr. Friedewald was introduced by VIRGIL WILLIAMS, Griffin, and several other Griffin doctors and hospital officials were guests for the program.

A. HAMBLIN LETTON, Atlanta, has been appointed to serve on the Steering Committee of the Atlanta Community Chest Drive.

R. BRUCE LOGUE, Atlanta, recently served for one week as visiting Chief of Medicine at the Atlantic City Hospital.

HAROLD P. McDONALD, Atlanta, led a discussion on urology at the recent AMA convention in Atlantic City. A new feature, "Queries and Minor Notes," was added to the convention's workshop by the scientific assembly. Dr. McDonald was chosen as urological consultant to answer questions and confer with physicians from all over the country.

JACK C. NORRIS, Atlanta, was elected a member of the International Academy of Pathology at Washington, D. C., May 31, 1955.

The *Journal* regrets to announce the death of Laurie May Cassily Quillian, wife of W. EARL QUILLIAN, Atlanta, on June 9, 1955. Mrs. Quillian had been ill for quite some time.

Dr. Goodrich C. White, president of Emory University, recently announced the following Emory University faculty promotions: J. ELLIOTT SCARBOROUGH, from assistant professor of surgery to associate professor; ALBERT A. BRUST, from assistant professor of medicine to associate professor; PATRICK C. SHEA, JR., from instructor in surgery to clinical assistant professor; and EDWARD D. REISMAN and NEIL TAPPEN, from instructors in anatomy to assistant professors. On the parttime faculty, EDGAR BOLING moved from associate in surgery to clinical assistant professor; GERALD R. COOPER, from clinical assistant professor of pathology

and instructor in medicine to clinical assistant professor of pathology and assistant professor of medicine; and JAMES C. THOROUGHMAN, from clinical assistant professor of surgery to clinical associate professor of surgery.

VIRGINIA TUGGLE, Decatur, has been appointed college physician for Agnes Scott College, officials of the college have announced. A graduate of Agnes Scott, Dr. Tuggle received her M.D. degree from the Women's Medical College of Pennsylvania. She has practiced in Decatur for several years and will continue her practice.

Sixth District

WILLIAM R. BIRDSOING, Macon, was guest speaker at a recent meeting of the Jaycee Auxiliary. He spoke on "Precaution to Polio and the Salk Vaccine."

A. W. BRAMBLETT, Forsyth, scored a 70 with his handicap to take the low handicap prize in the golf tournament sponsored by Chas. Pfizer and Company, Inc., for the Bibb County Medical Society. The tournament, played at the Idle Hour Country Club in Macon, had about 50 participants, and was followed by dinner at the club.

MARION W. HURT, Sandersville, has been elected president of the Sandersville Rotary Club for the 1955-1956. He succeeds OSGOOD M. BATEMAN in this office. Installation ceremonies were conducted on July 6 at the summer home of Mr. D. E. McMaster on Lake Sinclair.

Seventh District

HENRY C. GORMAN, formerly of Georgia Baptist Hospital in Atlanta, has moved to Smyrna to practice general medicine. He has taken over the office formerly occupied by GEORGE P. DILLARD, who with his family has moved to Augusta. Dr. and Mrs. Gorman and their daughter, Tanie, will live at 210 Hillside Road. Dr. Gorman received his M.D. degree from the California College of Medical Evangelists.

Directors of the Northeast Chapter of the Georgia Heart Association met on May 26 in Monroe to hear an address by J. H. PRITCHETT, Bremen. Dr. Pritchett is chairman of the state committee on public education for the Georgia Heart Association. He spoke on "Plans to Stop Rheumatic Fever."

ALLEN ROBERTS, whose home is in Alpharetta, recently came back to his practice in Marietta after having been in Kansas City, Mo., where he was a surgical resident in ophthalmology at the Kansas City Hospital for a year. He has opened an office in the old Marietta Hospital building. His wife, JESSIE M. ROBERTS, will continue to practice in Roswell in the office with her father, J. L. MORRIS. The Doctors Roberts will have their home in Alpharetta.

DON W. SCHMIDT, Cedartown, was elected president of the Cedartown Lions Club and first vice-president of the Chamber of Commerce.

Eighth District

J. A. LEAPHART, Jesup, attended the 21st annual meeting of the American College of Chest Physicians in Atlantic City where he was made a fellow of the college. While he was away from Jesup, DARRIEL G. KITCHENS took his place at the Leaphart Hospital.

ARTHUR M. KNIGHT, JR., Waycross, spoke at the meeting on June 6 of the Waycross Rotary Club. He spoke on mental illness, in cooperation with a local campaign being conducted by the Waycross Junior Women's Club to acquaint more people with this illness.

VILDA SHUMAN, Waycross, has been elected a fellow in the American Academy of Pediatrics. Dr. Shuman is a native of Monticello, Fla.; she graduated from the Georgia State College for Women and received her M.D. degree from the Vanderbilt University School of Medicine. She has done postgraduate work in Montreal, Quebec; Albany, N. Y.; Philadelphia, Pa.; and Rochester, N. Y. She practiced for two years in Richland, Wash., before coming to Waycross in 1948.

Ninth District

BEN K. LOOPER, Canton, was guest speaker at a recent regular Tuesday meeting of the Canton Rotary Club; his subject was, "Life, and How to Extend It." Dr. Looper gave 10 simple statements which, he said, if applied would do much to produce a longer life, and he reminded his listeners that the human body was not designed to withstand the strain and stress of modern living.

Dr. Looper has also recently been elected to the Canton School Board.

Dr. and Mrs. ROBERT T. JONES, Canton, announce the birth of a son, on May 28, 1955, named Christopher Reynolds.

Dr. and Mrs. T. N. LUMSDEN, Clarkesville, announce the birth of a son, Thomas N., Jr., on March 25, 1955.

Dr. and Mrs. GEORGE T. NICHOLSON, Cornelia, were in Augusta on June 1st and in Atlanta on June 2nd where they helped present the First Annual Senior Day Program for the senior medical students and their wives at the Medical College of Georgia and Emory University School of Medicine. The programs were sponsored by the Rural Health Committee of the MAG, of which Dr. Nicholson is chairman.

Tenth District

MORGAN CHARLES ADAIR, Washington, was recently written up in a feature column of the *Washington News Reporter* entitled "Hi Neighbor." In this more or less biographical sketch it was pointed out that this native of Marietta and Atlanta received his pre-med and medical training at Emory University and after intern-ing at Grady Memorial Hospital in Atlanta served in the Army Medical Corps. He went to Washington to practice medicine in 1945. Dr. Adair is a member of the Kiwanis Club, the Washington Methodist Church, and the Wilkes County Medical Society. He is a director of the Farmers and Merchants Bank and the Washington City Council. He is also mayor pro-tem.

The surgical staff of the University Hospital, Augusta, and their families were entertained at an alfresco supper in May by Mrs. Ernest Daniel in honor of her son, ERNEST DANIEL, JR., a member of the staff, and Mrs. Daniel.

LELAND D. STODDARD, Augusta, professor of pathology in the Medical College of Georgia, addressed the medical staff of the Veterans Administration Hospital, Dublin, on June 10th. The subject of his illustrated lecture was "The Myeloses."

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The oxygen content of this baby's incubator is being carefully checked to prevent his joining the ranks of the thousands of children who are blind because of retrolental fibroplasia. See page 417. Photo by Ted F. Leigh, M.D.

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J. K. Quattlebaum, Savannah—1957
Joseph C. Read, Atlanta—1957
R. F. Spanjer, Cedartown—1955

Representative from the Georgia Dental Association

Thomas Conner, Atlanta—1957

Representative, Georgia Nursing Association

Miss Dana Hudson, Atlanta—1957

Representatives, State at Large

Mr. Walter Graefe, Griffin—1957
Mr. J. J. McLanahan, Elberton—1957
Mr. Frank A. Smith, Clayton—1956
H. C. Derrick, Lafayette—1959
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T. F. Sellers, Director, State Health Department
Mr. Eugene Cook, Attorney General
Mr. Alan Kemper, Director, State Welfare Dept.
Mr. B. E. Thrasher, State Auditor

State of The Association

GEORGIA MEDICINE HAS BEEN BESET by a multitude of problems over the past years and has on many occasions through concerted Association action effectively sought and found the answers to the issues facing the profession. The purpose behind all of the Association's activities has been to improve the health and welfare of the citizens of Georgia.

The purpose of this report is to better focus your attention on the six most important issues now facing organized medicine in Georgia.

In the interest of finding the "best" answers, each and every member must consider the following problems and *speak out*—so that Association policy and resultant action may truly represent the will of the majority of Association members.

Georgia Hospitals

The Association is becoming increasingly aware of the fact that the profession must strive to better the medical care rendered in the hospitals of Georgia. The MAG Hospitals Committee submitted a resolution to the House of Delegates which was unanimously approved calling for "the creation on a state level of a joint commission to study and recommend hospital standards in Georgia as these standards relate to the medical profession."

Liberally interpreted by the MAG Hospitals Committee, this commission would seek to establish minimum standards for hospitals of less than 25 beds. Over half of the hospitals in Georgia have less than 25 beds, and it is believed that a set of minimum standards as a guide for these hospitals would bring improved patient care. This action in no way interferes with the national joint commission on accreditation of hospitals, as this body largely concerns itself with hospitals of over 25 beds.

Nor does the Hospitals Committee seek a "police" action in this field. The committee merely wishes to recommend certain minimum standards to aid the small hospital in rendering medical care to the best of its ability.

Because the physician is so closely connected to hospital organization and practice, it is the physician himself who must lead in both remedial and progressive action to improve the hospital situation in Georgia. In the public eye it is the doctor who is responsible for the hospital function, and the doctor has this responsibility to fulfill. As in any large state, there are substandard hospitals, and it is incumbent on the profession to "clean house" even though the

number be few. It is also the profession's task to ever improve medical care in hospitals, and with professional cooperation it is entirely possible.

Physician Distribution

Of great concern to the Association has been the placement of physicians to minister to the citizens of Georgia. This one problem has become a key in the Association's 1955-56 program. It is fact that there is *no shortage* of physicians in the state—but areas in the state suffer critically in the field of medical care because the distribution of Georgia physicians is too highly concentrated in the large metropolitan centers and is too "thin" in certain rural areas.

Again, as public service, the Association evolved a program to fill the physician need in these rural areas. A physician placement service was established and has effectively operated to aid physicians seeking rural locations and to assist rural locations in attracting physicians. Programs were given for the medical school seniors in Georgia to advise them of the advantages of rural practice. Cooperation with the State Medical Education Board in administering a scholarship program for medical students designed to facilitate their going into rural practice was inaugurated.

While the problem is nearing solution, it appears the full answer to the rural need of physicians lies within the profession. Again the cooperation of the Association's members is necessary to provide adequate medical care for *every* community in Georgia. If the profession wishes to reach this goal, this aim, the profession must actively work toward this end in ascertaining these critical areas and staffing them with competent physicians.

Cultists

The House of Delegates of the Medical Association of Georgia in special session on December 12, 1954, unanimously passed the following resolution: "RESOLVED, that the House of Delegates of the Medical Association of Georgia go on record as being unalterably opposed to the action of any member who associates himself (or herself) with any physician practicing the healing arts who is not a licensed doctor of medicine, except as specifically excluded by law."

More recently, the House of Delegates of the American Medical Association adopted a minority report clearly defining the practice of cultists as fol-

lows "... an appreciable portion of the current education in colleges of osteopathy definitely does constitute the teaching of 'cultist' healing, and is an index that the 'osteopathic concept' still persists in current osteopathic practice."

The laws of Georgia are so written as to protect the cultist rather than the public welfare, and as a result your state has become fertile field for many alleged branches of the healing arts. Other Southeastern states have enacted legislation to protect their citizens from practitioners with substandard medical education and the obvious unscrupulous "quacks".

It is the responsibility of the M.D. to see that the public receives the best medical care—and this responsibility should lead to actions designed to "curb" and "weed out" the cultist. Doctors must advise and educate the general public, sponsor and back legislation to limit and/or make illegal cultist practice, investigate and bring to light all instances of inadequate medical care.

Legislation and the Doctor

County, state and federal legislation has always affected the physician because it affects the health and welfare of his patients. In years gone by, the doctor believed it was sufficient to practice medicine and let civic affairs take their course. During the past 10 years, the physician realized that his very right to practice medicine was legislatively at issue—and to date the doctor has had to concern himself with legislation on every level. The physician must not only guard the prerogatives of his own profession but must also strive to be instrumental in effecting various types of legislation to improve the health and welfare of the citizenry.

It is not enough for the profession to be *against* improper legislation—the doctors must be *for* legislation written on advice of the profession in the interests of promoting better health. The physician must be a force in this civic community as well as the leader in the medical field.

The legislative committee of the Association has a tremendous job on all fronts and can only hope to succeed with the active aid of every physician. The doctors of Georgia can legislate in the medical field if they will make it their responsibility, and the need is now!

Medical Insurance

In the interest of the near-indigent patient, the Association has a voluntary, prepaid surgical and obstetrical service underwritten by some 30 insurance companies known as the Georgia Plan. This plan permits patients within certain income limits to obtain medical care at a fraction of the physician's usual fee. The plan, inaugurated some five years ago, has recently been revised to make it more attractive to the patient, the physician, and the underwriting in-

surance company. Members of the Association are urged to become participating physicians in this plan if they have not already done so. The plan and its past success represent positive action by physicians to insure the public welfare.

The Association has been concerned with the gradual, but steady, degradation of the profession in the courts of Georgia in connection with the many "malpractice suits" against physicians. It has been ascertained that only a small percentage of the suits filed are valid and justifiable. To rectify this grievous wrong, the Association has made available to its members group professional liability insurance administered cooperatively by it and St. Paul Mercury Insurance Company. It is believed that this plan, conceived in May 1955, will help maintain the prestige of the profession, a valued possession so frequently under attack in the past two decades. Again it is well to remember this plan represents the ideals of your profession and to succeed must have each and every member's cooperation.

Unethical Practice of Medicine

Your Association has in no uncertain terms taken a firm stand *against* the unethical practice of medicine as proposed in the Georgia Board of Regents' plan for the operation of the Eugene Talmadge Memorial Hospital at Augusta. This problem has yet to be solved to the satisfaction of the medical profession. Six other state medical associations are at the present time involved in solving this dilemma. It appears from the record that the Association's advice was not heeded by the authorities responsible for the administration of the Talmadge Hospital, and the Georgia doctors must either augment and implement this policy or accept the Regents' plan which the Association has declared to be against the interests of the public welfare and the profession.

The first step toward solution of the Talmadge Hospital problem was taken by the Association when the House of Delegates met to consider the issues at stake. The second development was the formulation of Association policy when the House of Delegates disapproved the Regents' operational plan on the grounds that it was and is unethical. No further action of the Association has yet been taken. It now is the responsibility of the physicians of Georgia to decide what further action should be taken in light of Association policy.

Resume

Briefly stated are six top priority problems facing the 2400 physicians in Georgia. The response and subsequent activity of these physicians in meeting the six issues squarely and resolving them to the best of their ability will determine both the State of the Association and the future of the Association.

Intravenous Cholangiography

H. STEPHEN WEENS, M.D., JASON L. MEADORS, M.D., and
WILLIAM A. REID, M.D., Atlanta, Ga.

THERE IS LITTLE DOUBT that the introduction of cholecystography by Graham and Cole¹ in 1924 represented a most important advance in the diagnosis of gallbladder disease. Since the original description of this method, many improvements of contrast media as well as refinements of roentgen technique and interpretation have made cholecystography an increasingly accurate diagnostic procedure. Early in this development it was realized, however, that in the study of many biliary tract disorders gallbladder visualization should be supplemented by roentgen demonstration of the biliary duct system.

Concurrently with progress in this field, efforts were therefore directed to expand contrast visualization of the gallbladder to that of the entire biliary duct system. If some of the newer gallbladder contrast media are used and special evacuation techniques are employed, visualization of the cystic duct and common bile duct has become feasible in a high percentage of cases provided that the contrast medium is adequately concentrated by the gallbladder. However, in the presence of impaired gallbladder function or in the post-cholecystectomy state, opacification of the biliary tract has remained largely unreliable.

Recently a new contrast medium has been introduced, Cholografin,[®] which is excreted by the liver in sufficiently high concentration to render the intrahepatic and extrahepatic duct system radiopaque.² Under these conditions the roentgen visualization of the biliary duct system depends no longer upon the ability of the gallbladder mucosa to concentrate the contrast medium. Also, as this compound is quickly excreted by the liver, it lends itself well to rapid cholecystography. Most reports concerning this contrast medium have been recorded in the foreign

literature.³⁻⁶ Recently, however, a number of studies evaluating this compound have been initiated in this country.⁵⁻⁶

The following observations are based on experience with approximately 100 intravenous cholangiograms with Cholografin*. Patients with a wide variety of biliary tract disorders were examined as well as normal individuals, as it was intended to evaluate the normal cholangiogram, determine effects of cholangiography on hepatic function, and study renal excretion of the compound.

Contrast Medium and Technique of Administration

Cholografin is the Di-sodium salt of N,N'-adipyl-bis-(3-amino-2,4,6-triiodo)-benzoic acid with an iodine content of 64.32 per cent. The contrast medium is available in a clear 20 per cent solution which is almost isotonic. As Cholografin is poorly absorbed from the gastrointestinal tract, it has to be administered intravenously. Under normal conditions, approximately 90 per cent of the contrast medium will be eliminated by the biliary tract, the remainder being excreted by the kidneys. In general the same precautions and preparations are employed as indicated for intravenous urography.

In most of our cases 40 cc. of the 20 per cent solution was administered slowly in five to 10 minutes in order to minimize side reactions, such as nausea, vomiting, flushing of the skin, and urticaria. In a small series of rapid injections we have noticed an increasing number of untoward effects, but with prolonged injection time the type and frequency of side reactions are similar to those encountered in intravenous urography.

The radiographic examination is performed in a slight left anterior prone projection which will clear the biliary tract region from the bony structures of the spine. Other projections as well as tomography

*This contrast medium was kindly supplied by Dr. Mark H. Lund, The Squibb Institute for Medical Research.

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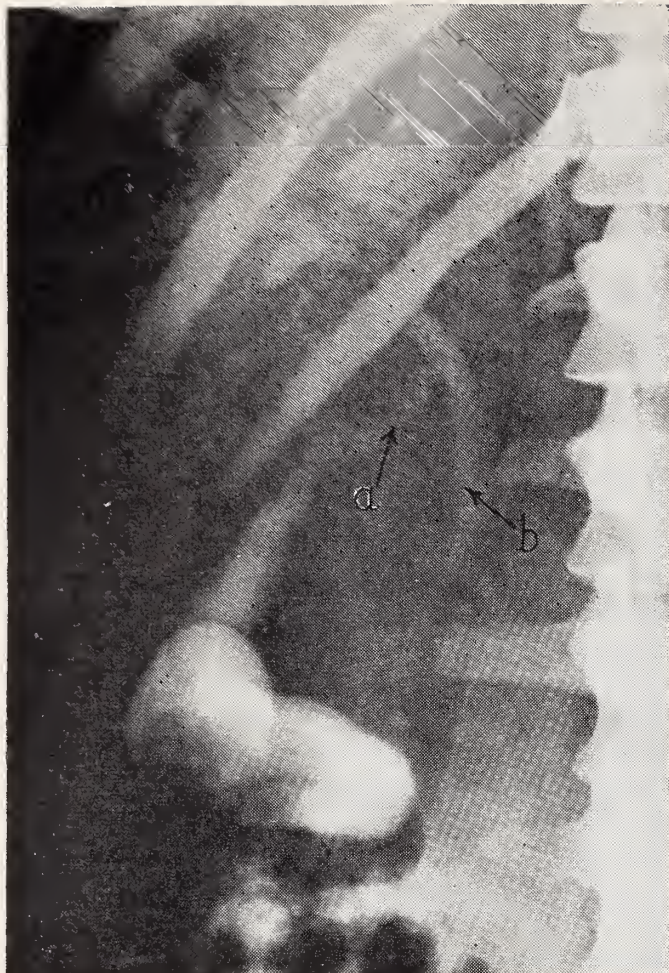


Figure 1

Normal intravenous cholangiogram and cholecystogram.

a. Cystic duct.

b. Common bile duct.

are sometimes found to be advantageous. The radiographic factors are essentially the same as required for cholecystography.

The Normal Intravenous Cholangiogram and Cholecystogram

Opacification of the biliary duct is usually noted 10 to 20 minutes following the injection of the contrast medium. Roentgenograms taken 10 to 20 minutes later will depict the main hepatic duct and common bile duct with greater intensity, though visualization of the smaller biliary radicles remains usually unsatisfactory. As early as 10 to 20 minutes following injection the contrast medium may be seen to pass into the cystic duct, but adequate gallbladder opacification should not be expected until 30 to 60 minutes have elapsed (Figure 1).

One should recognize that incomplete mixing of the contrast medium with the non-opaque gallbladder bile may cause a number of spurious filling defects in the gallbladder shadow which should not be misinterpreted as calculi (Figure 2).

There are as yet no generally recognized standards established with reference to average and maximum diameters of the common bile duct. Values up to eight mm. have been considered within the normal



Figure 2

Intravenous cholangiogram 40 minutes following intravenous injection of contrast medium. Duct system well outlined. Gallbladder incompletely filled. The central radiolucencies of the fundus should not be mistaken for stone formation.

range by some observers.⁷ Studies in our department on some 40 normal individuals have revealed that the caliber of the bile duct system varies with age. Most young individuals have a common bile duct which measures not more than two to three mm. in diameter. In older normal individuals, however, measurements up to six to seven mm. have been frequently encountered.

As soon as the contrast medium passes from the biliary duct system into the duodenum, reflux of the compound into the region of the duodenal cap or even stomach may occur. It is noteworthy that the opacified duodenal cap may, to some extent, simulate a small gallbladder shadow, which may give rise to confusion in those instances of post-cholecystectomy states in which regeneration of the gallbladder is suspected. In these cases oral administration of barium may aid in the differentiation of these structures.

Effect of Intravenous Cholangiography on Liver Function

As Cholografin is primarily excreted by the biliary tract, an attempt was made to determine whether its clinical application would adversely affect hepatic

physiology. For this reason liver function was studied in more than 40 normal and pathologic cases shortly before and following intravenous cholangiography with a series of laboratory tests such as determination of bromsulphalein retention, serum protein levels, cephalin flocculation test, and thymol turbidity test. In a smaller series of patients these tests were repeated at various time intervals in order to uncover possible latent hepatic damage. The results indicate that there were only minor fluctuations in these liver function tests as one should expect in the natural course of disease in these patients. The lack of significant changes makes it very likely that administration of the contrast medium appears to be safe in the dosage range currently recommended.

In patients with marked impairment of hepatic function, most of the contrast medium will be excreted by the kidneys resulting in a pyelographic effect. It has been suggested⁸ that observation of renal excretion may be a sign of impaired hepatic function, but analysis of our data indicates that early excretion occurs quite frequently in patients with normal liver function. Radiologic observation of renal excretion should therefore not be taken as evidence of liver damage.

Clinical Experience

With few exceptions, satisfactory opacification of the biliary ducts and gallbladder is obtained in normal individuals provided that proper technical factors are observed.

The large variety of biliary tract disorders often associated with wide derangements of hepatic function makes it difficult to evaluate in this small series the merits of intravenous cholangiography, especially in comparison with oral cholecystography. In several clinical states, however, certain impressions were gained which may be worthy of description.

Acute Cholecystitis

A total of nine patients with acute cholecystitis were examined by intravenous cholangiography during the acute phase of their disease. In none of these patients was it possible to obtain filling of the gallbladder, but in six patients common duct opacification was noted.

The lack of gallbladder opacification may serve to corroborate the clinical diagnosis of acute cholecystitis. However, the value of intravenous cholangiography in the differential diagnosis of acute abdominal conditions will depend upon the results of the method in other acute abdominal disorders. The procedure was well tolerated by all patients in this group.

Clinical Jaundice and Hepatic Dysfunction

Our results in patients with clinical jaundice were disappointing. In only one of 10 patients biliary duct and gallbladder opacification could be observed.

Many of these patients had considerable impairment of hepatic function or marked degrees of common duct obstruction which would have made a satisfactory examination with this compound unlikely. Nevertheless the failure of the intravenous cholangiogram to yield more conclusive results in this group of patients is regrettable, as in patients with jaundice common duct visualization would be of utmost importance.

In the absence of significant jaundice the BSP test may serve as a guide in the selection of patients for intravenous cholangiography. It has been found⁴ that in the presence of 20 per cent BSP retention in 45 minutes satisfactory duct visualization may be obtained. With increasing retention the examination may be expected to be unsuccessful. Among our own patients adequate duct opacification was observed in the presence of 16 per cent BSP retention.

Choledocholithiasis and Cholelithiasis

It is in this clinical entity that intravenous cholangiography may find its most important application. In all patients with multiple gallstones, duct visualization with intravenous cholangiography should be attempted. In this manner it may be possible to detect calculi in the duct system which would not be



Figure 3

Intravenous cholangiogram 60 minutes following intravenous injection of contrast medium (tomogram). The arrows point to a row of small calculi in the common bile duct.

discovered by oral cholecystography. Figure 3 demonstrates a row of small calculi in the common bile duct and common hepatic duct in a patient whose gallbladder was packed with numerous small stones. Frequently in cases of cholelithiasis oral cholecystography will fail to opacify the gallbladder. With intravenous cholangiography, in a certain number of these cases, gallbladder visualization may be obtained permitting by demonstration of stone formation a more precise diagnosis.

In patients in the post-cholecystectomy state intravenous cholangiography appears most valuable in the recognition of choledocholithiasis. The importance of changes in the caliber and profile of the common bile duct has as yet not been fully evaluated and requires further comparative study in symptomatic and asymptomatic patients.

Other Applications

There are other applications of intravenous cholangiography which deserve further evaluation. Many of these are dependent upon a greater knowledge of the physiology of the biliary duct system and sphincter of Oddi. To some extent this information may be provided by the method itself. Conceivably with broadening experience a clearer concept of such conditions as biliary dyskinesia may be obtained expanding further the field of x-ray diagnosis of biliary tract disorders.

Summary

- (1) Intravenous cholangiography and cholecystography with a new contrast medium, Cholografin, is described.
- (2) An outline of the technique of the examination is given and the appearance of the normal cholangiogram and cholecystogram is demonstrated.
- (3) A preliminary impression of clinical results obtained with this compound is presented.
- (4) The effects of intravenous cholangiography on hepatic function as well as the renal excretion of Cholografin are discussed.

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More Rural Doctors For Georgia

THE ANNOUNCEMENT THAT the first nine graduates under Georgia's program of aid to medical students are now entering upon their year of internship and will be ready to begin practice in July of next year directs attention to this most worthy program.

A few years ago Georgia embarked on a project of giving financial aid to deserving medical students who did not have the financial resources to pursue their chosen profession. Those accepting such aid entered into an agreement to practice for a period of years in designated rural areas in the state.

Seven of this first nine graduated from the University of Georgia Medical School, one from Tennessee and the ninth, the one Negro in the group, from Meharry in Nashville, Tenn. All of them made good records and, when they have completed their internships, should be fully prepared to relieve the serious shortage of doctors in certain rural areas.

In this connection it is interesting to note that 32 more young Georgians have been selected to receive aid in completing their medical education.

Forty-three previously awarded scholarships were approved for renewal. This brings to 75 the number

who will be continuing their studies for medical degrees next year.

The cost of medical education is very high. Not all those young people with ability and a desire to become doctors can pay their way. There is a great need for rural doctors in the state and it is gratifying that the state has embarked on a program that, in time, will provide a number of well trained doctors who will be practicing in our rural areas.

The first nine to be graduated under the program will be followed by others and, as the years go by, Georgia's need for more and better medical care will be relieved.

Georgia is looking ahead and medical care for our people is one of the things that we have recognized as a pressing need. It is all very well to talk of new industries, better farming practices, improved forestry programs and the like, but we need to give thought to our growing health problems and these young doctors who are preparing to meet the needs of our people should be encouraged in every way.

(Reprinted from the Valdosta Daily Times)

A Severe Case of Boric Acid Poisoning with Survival

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IN RECENT YEARS reports of boric acid poisoning in infants and children have appeared with increasing frequency in the pediatric and surgical literature. Since the danger of boric acid poisoning is more common than is generally appreciated, it becomes necessary to call the attention of all practitioners of medicine to this pediatric hazard.

The following case report was of interest to us because of the fact that we treated it without a definite diagnosis, because of its severity, because of its recovery, and because of our use of cortisone. We would also like to add this case to the medical literature as another thorn in the sides of diagnosticians so they will not make the same error of forgetting a simple diagnosis as we did. We shall relate this story as it was presented to us, and bring out the interesting highlights in the discussion that follows.

Case Report

R. H., a six-week-old white male, was brought to the Mercer Blanchard Pediatric Group on November 16, 1953, with symptoms of diarrhea for several days and vomiting for 24 hours. The patient was born of a perfectly normal full term delivery and had done well on an evaporated milk formula until about two or three days before he was seen by us. At that time, he began having frequent greenish, watery, and mucoid stools. He had had no fever or upper respiratory infection.

He weighed 7 lbs. 9 oz. and was 21.7 inches long. Nothing remarkable was found on physical examination except mildly excoriated buttocks. He was taken off milk and put on a sugar and salt water solution, plus kapectate until he was seen the following day. His bowel movements were then less frequent but still quite watery, and he vomited once. Because of apparent improvement he was put on a low fat powdered milk formula. By the following day, November 18th, his bowel movements were still very loose in consistency, and he refused to take his milk and medication.

His weight had fallen to 7 lbs. 8 oz., and he appeared mildly to moderately dehydrated. While in the office he began to have mild generalized clonic convulsions and was very spastic. His fontanelle was flat, and there was moderate excoriation of the buttocks. He was hospitalized.

Immediately upon arrival at the hospital the patient was given a subcutaneous clysis of glucose and saline and intravenous calcium gluconate. He was ordered glucose water by mouth, two gm. calcium lactate daily, intramuscular aqueous penicillin, 50,000 units q6h, and streptomycin, 50 mg. q6h.

On November 19th, the day after admission, he was still quite spastic, holding his head in opisthotonus, still having large liquid, green stools, in spite of the oral intake of only glucose water, and was still moderately dehydrated. His buttocks were even more excoriated. He appeared much worse. He was taken off everything by mouth and intravenous fluids were administered through a phlebotomy. A heat lamp was applied over the

buttocks, and it was noticed that there was desquamation of the skin over the buttocks and thighs. A spinal tap was performed, and the fluid was normal. The laboratory data at this time revealed a RBC 3,000,000; hemoglobin, 8.8 gm. per 100 cc.; WBC 6,350, 1% eosinophiles, 10% stab forms, 21% segmented forms, 58% lymphocytes, 10% monocytes. Urinalysis gave negative results. CO₂ combining power was 36 volume and NPN was 88 mg.%. For the first two days of hospitalization the patient's temperature remained between 96.4 and 99.8 F., being sub-normal most of the time.

On the following day, November 20th, the patient's condition seemed critical. He continued having very large greenish, mucoid, watery stools, and there was more desquamation of the skin even over the trunk, and a positive Nicolski sign was present. His hydration, however, seemed somewhat better at this time. It was our impression that he probably had Ritter's disease. He was maintained on parenteral fluids, and correction for CO₂ deficit was made. He was given calcium gluconate, potassium chloride, and ascorbic acid in addition.

On the third hospital day, November 21st, the patient suddenly went into collapse, became very pale and cyanotic, quite unresponsive to all stimuli, and appeared moribund. Respirations were extremely shallow and were gasping in nature. He actually appeared lifeless. Rales were heard throughout the right chest and the heart sounds were very weak and distant. His mouth was extremely dry, and the cornea had a markedly dehydrated appearance. The liver edge was down three fbs. below the right costal margin. The temperature was 95F. It was thought at this time that the patient probably had broncho-pneumonia and was unquestionably in heart failure (in retrospect, he probably was not). Blood chemistry at this time showed a blood serum chloride of 729 mg.% (normal 575-630) and NPN of 41.5 mg.%. Oxytetracycline (Terramycin®) was given intravenously and the patient was also digitalized. Caffeine sodium benzoate was given for respiratory stimulation. Oxygen was administered through a tent. A marked desquamation was noted generally over the face, trunk, and extremities. Hot water bottles and a heat lamp were used in an attempt to elevate the body temperature. We had practically given up hope for the patient by this time, but he was still alive on November 22nd, at which time his temperature rose to 102 F, and his respirations improved somewhat, but were still gasping in nature, and he still appeared moribund. There were some clonic twitchings of his extremities. Because of the marked desquamation we started him on cortisone 12.5 mg. q6h intramuscularly and also applied Ilotycin® ointment to all involved skin areas. There was distention of the abdomen which was relieved by rectal tube. By the late morning and early afternoon of the 22nd, his pulse and respiration became rapid, and his color definitely improved. By late evening respirations were quieter and easier. His skin continued to desquamate in large sheets, particularly over the thighs, lower abdomen, and scrotum. The scrotum was edematous.

On November 23rd, the fourth hospital day, the patient definitely seemed improved, was much more alert upon stimulation, his chest seemed to be clearer, and his respirations were normal. He was still having liquid, green stools, however, and occasionally they were tarry. His blood chemistry on this day revealed a blood chloride of 650 mg.% an NPN of 39 mg.%, an RBC of 3,740,000, Hbg. of 11.5 gm. % and a WBC of 1,950, 1% eosinophiles, 15% stabs, 24% segmenters, 7% lymphocytes, 3% monocytes. His temperature ranged between 99.2

to 101.6 F., occasionally going to 102 F. His eyes, at this time, looked as though there was no perception of light. The corneas were completely hazy and dry and seemed to have no life. Warm, moist, saline pads were ordered on the eyes continuously. He could not close his eye lids. By late afternoon on the 23rd, he seemed to move somewhat and actually made attempts to cry which he had not done previously. At this time there seemed to be a progressive improvement. An x-ray taken on the 23rd showed evidence of bilateral massive pneumonia and some atelectasis. Because of the improvement, the patient was started on glucose water by mouth which he tolerated. Cortisone was gradually tapered and the crystodigin stopped. Intravenous fluids were continued, however, until November 26th, which made five days of parenteral therapy.

He appeared very alert at this time but did not appear to see. There was marked spasticity of the extremities with almost a claw-hand deformity of his hands. Decubitus ulcers were noted on his buttocks and also on his thighs. He also had developed bilateral phlebitis from the phlebotomies that had been performed during the period of parenteral therapy. His WBC on the 24th was 1800, 1% basophils, 4% Eosinophiles, 2% stabs, 6% segmenters, 79% lymphocytes, 8% monocytes. By the next day, the 25th, however, his blood count had come up to 3,500, 31% segmenters, 61% lymphocytes, 8% monocytes. It was also noted that his platelet count was 34,200; this rose to 55,040 by the 27th. He was put on a diluted low fat, high protein milk formula which he took well, and this was gradually increased. He continued to have a cough for which he was given chloromycetin by mouth. The ulcerations were treated with Ilotycin ointment and cleaned and dressed daily. He was discharged on the 13th hospital day in fairly good condition and was followed at the office.

When he returned to the office on December 2nd, he weighed 7 lbs. 2 oz. His bowel movements were still loose, and he lost some weight after about a week at home. His milk was changed to a lactic acid milk with banana powder added. He seemed to improve and began to gain weight again; by December 12, 1953, he weighed 8 lbs. 2 oz. and was taking solid foods well. The ulcerated areas on his thighs gradually healed and his eyes returned to normal.

Discussion

We treated this patient the entire time symptomatically and had no definite diagnosis. We had considered him a case of severe gastroenteritis, generalized sepsis, Ritter's disease, and pneumonia. We had considered the drop in blood count secondary to the overwhelming infection.

On January 8, 1954, during a routine follow-up visit to the office, the patient's mother stated that she knew what her baby had had and produced an article by Dr. Herman Bundesen on boric acid poisoning, stating that she thought her baby fitted the symptom complex. Upon questioning her at that time, it seems that the baby had had intermittent diarrhea for about two weeks prior to admission and also had had some irritation of the buttocks, for which the mother had applied pure USP boric acid powder for at least two days before we saw him. Everytime she changed the diaper she would dust on this powder, and she also bathed the baby in boric acid powder by putting one teaspoon of the powder to a quart of warm water. She noted that the rash became worse under this treatment, that the baby started vomiting only after she had started using the boric acid powder, and also that the diarrhea had become worse.

With this history, we then knew at once we had been dealing with a case of boric acid intoxication,

and in retrospect we could see that all the symptoms were characteristic of a severe poisoning from boric acid from the very inception with vomiting and diarrhea, severe dehydration, collapse, cyanosis, pneumonia, exfoliative dermatitis, involvement of the eyes, convulsions, and spasticity. Whether the drop in blood count is characteristic of boric acid poisoning we cannot say. We have not seen this reported or commented upon elsewhere in the literature. In reviewing the chart in order to report this case, we noted for the first time that the patient had been getting boric acid irrigations to his eyes frequently during the day instead of the normal saline ordered. Whether or not this had anything to do with worsening of the patient's condition on the third day of hospitalization, we cannot say.

Cortisone was used on this patient because of its known effectiveness in exfoliative dermatitis. He survived. From all published reports of such a severe case of boric acid poisoning, this infant should have died. Whether the cortisone contributed to this survival by giving adrenal support to a severely ill patient or whether it had some effect on counteracting the effect of the boric acid, we, of course, cannot say. We do feel that more clinical experience with the use of cortisone in this type of poisoning is definitely in order.

Boron compounds have been used for many centuries in medical practice, particularly as irrigants for accessible body cavities and for topical applications usually with the illusion of antisepsis. Drugs are used many times not so much for the good they do as their failure to do harm. However, this has not proven the case with boric acid. Fatal cases of poisoning were reported as early as 1851. The first clinical description of poisoning in an infant was recorded by McWalter¹ in 1907. This infant developed poisoning from having its mouth treated for thrush by applications of borax and honey.

There are many routes through which boric acid may enter the body to cause poisonings. Aikman² has referred to a fatal case in a two-day-old nursing infant whose mother's nipples had been cleansed with boric acid solution. It had been shown that boric acid is not absorbed through the unbroken adult human skin. However, there is an extremely high degree of absorption from broken skin surfaces, serous cavities, and the gastro-intestinal tract, and a typical case has been reported in a two-year-old child following repeated applications of boric acid ointment to a burn measuring only 3 by 12 cm.⁴ In humans boric acid may be used for several days before the onset of acute symptoms.⁵ Symptoms may be minimal until a lethal or near lethal dose has been absorbed.¹³ Excretion is slow in man, apparently

requiring several days for excretion of a single large dose, and this type of excretion also suggests that the poison may be cumulative if single sublethal doses are repeated daily.⁶ Percutaneous absorption to cause intoxication appears to be made possible by conversion of the boric acid dry particles to boric acid solution when collection of urine occurs about the diaper rash region to which the boric-acid-containing powders were applied.⁷ Recent studies by Johnstone and associates⁸ indicate that the generally available borated baby powders constitute a hazard only when a considerable area of skin is denuded. The young infant is particularly susceptible. However, recently Vignec and Ellis⁹ proved that the average borated powder which contains five per cent boric acid is usually harmless. They exposed infants to an average of 2.33 gm. of boric acid daily in the form of borated talc for a number of weeks, and the results of absorption obtained in both the control and test groups fell close to the normal values, which are for blood, 0.04 to 0.09 mg. per 100 cc., and for urine 0.07 to 0.15 per 100 cc.

The explanation for the lack of absorption of boric acid in talc and the ready absorption of boric acid in solution lies in the fact that ionized forms are not transmitted through the skin as readily as undissociated molecules. Boric acid, when mixed with talc and subsequently wetted, yields a much higher degree of dissociation, due to salt formation with the alkaline components of the talc, than does boric acid in solution.

No minimal lethal dose is known. In six members of a group of fatal poisonings under two weeks of age reported by Young¹⁰ and collaborators, the amount ingested accidentally was less than three grams in each instance. It was found by Buzzo and Carratala¹¹ that one gram per kilogram of boric acid administered to dogs caused nervous and muscular paralysis.

There are no characteristic changes on post-mortem examination, but the findings are consistent with the effects of a chemical irritant and are most prominent at the site of excretion (urinary tract 85-100 per cent, gastro-intestinal, and the skin), and of maximum body concentration (brain and liver). Edema of the brain with flattening of the convolutions has been seen in some cases. Varying degrees of hemorrhagic enteritis are common findings, as are degenerative changes in the liver, characterized by cloudy swelling, and in some cases central necrosis. Microscopic changes in the skin are limited to epidermis and consist of edema, degenerative changes in the keratin, and desquamation. Goldbloom and Goldbloom¹² reported a case of boric acid poisoning which died and at post-mortem showed an extensive

hemorrhagic consolidation due to widespread intra-alveolar hemorrhage. The cause of the hemorrhage was not determined, but we suggest thrombocytopenia as we witnessed in our case. It has been suggested that boric acid causes a depression of the bone marrow when used to treat burns, but there seems to be no real evidence for this.

A typical clinical picture usually begins with nausea, vomiting, abdominal cramps, and diarrhea. The gastro-intestinal symptoms occur even though the boric acid enters the body by some other route. In a review of 109 cases of boric acid poisoning from the world literature,¹² it was found that the commonest clinical findings were referable to the nervous system, 67 per cent; gastro-intestinal tract, 73 per cent; and skin, 76 per cent of children, and 88 per cent in children under two years of age. In younger patients the common findings are those of meningeal irritation with convulsions, delirium, and coma appearing frequently.

Often there is progression to cyanosis and collapse. The mechanism of the peripheral vascular dilatation and shock is not known. Death seems to occur from central nervous system depression. In adults, headache, marked weakness, and excitement or depression have been reported. The typical skin findings consist of an intense erythematous eruption ("broiled-lobster" appearance) often covering the entire body, followed in one or two days by extensive desquamation.

Goldbloom and Goldbloom¹² remark on the similarity between these cases and Ritter's disease, and wondered as we do as to the number of cases of Ritter's disease which were actually boric acid poisoning. Even in our own nursery, until recently, the conjunctivae were often bathed with boric acid solution, umbilical stumps dusted liberally with boric acid powder, infant's mouth cleansed with boric acid solution, and finally mother's nipple cleansed with boric acid solution prior to nursing. It is certainly conceivable that cases of so-called Ritter's disease in the past could have been boric acid poisoning.

A rapid confirmation of boric acid poisoning can easily be made by the turmeric paper test. The solution to be tested is first strongly acidified with concentrated hydrochloric acid, and freshly prepared turmeric paper is then dipped in the solution and dried in the air. The appearance of a pink to red color denotes the presence of boric acid. A rapid confirmatory test consists of placing a drop of concentrated ammonia water on the tested paper. A transient blue-black color confirms the presence of boric acid.

The treatment of boric acid poisoning is purely symptomatic. Whether cortisone will play a role in

the treatment remains to be seen.

In conclusion, we would like to quote from Goldbloom and Goldbloom,¹² "Boric Acid has no bactericidal activity. It will inhibit the growth of certain organisms but only temporarily. It adds nothing to the irrigation properties of water or physiological saline, and yet its presence is still to be found in eye drops, ear drops, cleansing solutions, ointments, and baby powders. Its history in therapeutic usage is punctuated by an ever-increasing number of warnings against its toxicity and by testimonials to its lack of useful function. In pediatric practice, its use in the prevention and treatment of ammoniacal dermatitis is no longer defensible. We would recommend, therefore, that boron compounds in any form be withdrawn from use in medical therapy." We do not feel this strongly about it. We do feel that this does not mean that one should abandon the use of talcs which contain small amounts of boric acid in a nonabsorbable form, since there is no evidence whatsoever in the literature or in practice that such products are dangerous. Powdered boric acid should not be dispensed "over the counter" to the public, nor should preparations of boric acid in solution be per-

mitted where any possibility of human error may enter into their administration.

Summary

An interesting case of boric acid poisoning has been presented which was diagnosed in retrospect. The possible value of the use of cortisone is discussed because of the unexpected survival of the reported case. A brief review of the signs, symptoms, pathology, and diagnosis is made.

204-11th Street

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Survey of Health Insurance

THE MACS AND THE JOES and the Marys and Helens who make up the American public apparently have taken to heart the old A.M.A. campaign motto, "The Voluntary Way is the American Way." The recent ninth annual survey of health insurance of America, as of December 31, 1954, made by the Health Insurance Council, New York, shows that nearly two out of every three men, women and children in the United States now are protected by voluntary health insurance.

By the end of June, some 104 million persons had voluntary health insurance against hospital expenses. About 89 million people had surgical expense protection, and 50 million had regular medical expense protection.

The total of benefit payments on health insurance claims reported by the survey for 1954 exceeded \$2.7 billion, a gain of 11 per cent over the previous year. Of the total amount, more than half went to help meet the hospitalization expenses of beneficiaries, and more than \$730 million went for surgery and medical care. Benefit payments to policyholders by insurance companies for loss of income due to disability totaled in excess of half a billion dollars last year, the survey reports.

Of the aggregate benefit payments in 1954 by all

forms of voluntary health insurance, 56 per cent of the total came from the insurance companies. The dollar amount paid by the companies was over \$1.5 billion, including loss-of-income benefits.

Blue Cross and Blue Shield type plans paid more than \$1 billion, or 39 per cent of the total. Various independent plans accounted for the remaining five per cent of the total.

On December 31, 1954, a total of 101,493,000 Americans had hospital expense protection. This represents an increase of 4.3 per cent during that year, a rate of increase which is over 2½ times the rate of population growth in the same period. Since the beginning of 1941, the number of persons with hospital expense protection has multiplied nearly 8½ times.

Nearly 86 million persons had surgical expense protection by the end of 1954. This represents an increase of 6.1 per cent over the previous year. Ordinarily, people with surgical coverage also have hospitalization protection. So, up to 85 per cent of those with hospital expense protection also had surgical coverage—up from a figure of 83 per cent one year earlier. Since 1941, the number of persons with surgical insurance has multiplied about 16 times.

An Unusual Case of Giant Hydronephrosis

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IN 1947, HOFFMAN¹ added nine cases of massive hydronephrosis to 89 cases existing in the literature. The criteria for massive hydronephrosis is one that contains one thousand cubic centimeters or more of fluid. Davis² added an additional case in 1953. In the eighteenth century, Glass reported a case in which 30 gallons of fluid were present. However, it is the consensus of opinion that this report is greatly exaggerated. Sauer³ believes that the largest hydronephrosis reliably reported was one containing 17 liters. However, Papen believes Dumreicher's case of 36 liters and Frank's case of 30 liters, represent trustworthy reports. Several reports, which need not be mentioned here, are considered unusual. The major number of cases averaged from 2,000 to 8,000 cubic centimeters.

The following case is presented primarily for the diagnostic problem it presents to the physician dealing with fluid in the abdomen. Secondly, its massive size, containing 10 gallons of fluid, merits recording in the literature.

Case Report

A colored male, age 27, was admitted to the City Hospital, Columbus, Georgia, January 16, 1954. He claimed abdominal enlargement as his chief complaint.

As far back as he could remember he thought his abdomen was enlarged. At the age of 14, he became aware of difficulty in bending forward when trying to do calisthenics. He was seen by a physician, at which time a paracentesis was performed. Multiple paracenteses were performed by three different physicians when the patient was 17, 19, 21, and 25 years of age. After each aspiration, he was uncomfortable until refilling would occur. Enlargement of abdomen always began in the left flank. On one occasion he was placed on strict bed rest for two years, a diagnosis of rheumatic fever having been made.

He had been fairly active physically and was a life guard for several summers. Life saving examinations were passed without difficulty. Basketball, volleyball, and tennis were also participated in.

In 1944, he fell on his side and back and developed hematuria, which lasted for one day. Other than this, he has had no serious illnesses, except for the usual childhood diseases.

Review of Symptoms:

Cardio-respiratory—mild dyspnea as his abdomen enlarged. No cyanosis, cardiac pain, or pitting edema.

Gastro-intestinal—good appetite, proper regular elimination, normal color and texture of stools.

Genito-urinary—no bladder symptoms such as frequency, dysuria, or nocturia.

Skeletal—Patient states that he has always had a rather large chest.

Physical Examination, the positive findings are as follows:

General—Twenty-seven year old colored male, six feet, one inch tall, with thin arms and legs and a very large protruberant

abdomen, which causes his chest cage to flair at its inferior margin.

Chest—An increase over the normal in both the AP and lateral diameter of the chest was obvious. There was marked flaring of the lower rib cage, separation of the ribs, and the entire rib cage rose with each respiratory movement.

Abdomen—Very large, protruberant, tense, and dull to percussion. It measured 46 inches in circumference.

Laboratory—RBC 5.7M, WBC 2450, Hb 91%; Urinalysis—Sp. Gr.—1.022, Alb. 1 plus, WBC 15-20, RBC 5-10; Kahn—Negative; Blood Chemistry—Amylase 225, chlorides 480, NPN 35.

On January 15, 1954, a paracentesis was done, and slightly over 10 gallons of fluid was obtained. There were no ill effects from the procedure. His weight on admission was 230 pounds, and the day after the paracentesis it was 165 pounds.

A chest X-ray showed the lung fields to be clear and the heart enlarged to the left. An intravenous pyelogram was carried out on January 18, 1954. The right kidney and ureter appeared to be normal. There was no function of the left kidney. The intestines were seen displaced toward the midline. The left flank was filled with a homogenous mass.

Cystoscopy was performed on January 19, 1954. A No. 21F cystoscope was easily passed into the bladder, which appeared normal. A No. 4F catheter was then inserted into the left ureter for 27 cm. A flat plate showed the catheter to be in normal position. Twenty cubic centimeters of Skiodan was then injected but did not appear on the X-ray film. The catheter was withdrawn into the upper ureter and another 100 cubic centimeters were injected. This showed the ureter to be of small caliber with what appeared to be a stricture in its upper portion. The opaque media, however, passed beyond this point and then gradually faded into an ill-defined dense area which occupied the entire left upper quadrant of the abdomen. At no time was any of the collecting system visualized. From the X-rays, it appeared that the kidney had been replaced by a massive cyst, either renal in origin or intimately related to it.

Surgical intervention was performed on January 21, 1954. A transperitoneal approach was elected as being the operation of choice. A left rectus incision was made, extending from a point lateral to the umbilicus almost to the twelfth rib. After opening the peritoneum, a large thin walled mass containing fluid was seen filling the left retroperitoneal half of the abdomen. The posterior peritoneum was then opened over this mass, and the mass was freed from the surrounding tissue. This was done easily, as there were very few dense adhesions. The ureter was now seen entering the lower pole of this mass. No band, afferent vessel, or stricture was noted. The ureter was then clamped and ligated. The mass was dissected into the left flank, and a small pedicle was identified. This was clamped and ligated and the mass removed. A drain was inserted through a stab wound and a standard closure completed.

The patient made an uneventful recovery following the operation, and his condition is now excellent. The flair of his ribs is decreasing, and his abdomen is slowly improving in cosmetic proportions.

The specimen was taken to the laboratory where the pathologist inserted a trocar and introduced 15 liters of water. However, this did not nearly fill the sac to its proportions in vivo. It measured 15x39x11 centimeters. Following this, the sac was opened, and several pocket-like areas were seen in its wall. These were presumed to be the remnants of dilated calices. The ureter was seen entering the lower pole of the mass, and at its upper pole a small mass of kidney tissue was seen.

The pathological report was as follows:



Figure 1

The hydronephrotic sac partially filled with fluid. The ureter can be seen coming off the left.



Figure 2

The sac after having been opened. Remnants of dilated calices can be seen at several places on the surface.

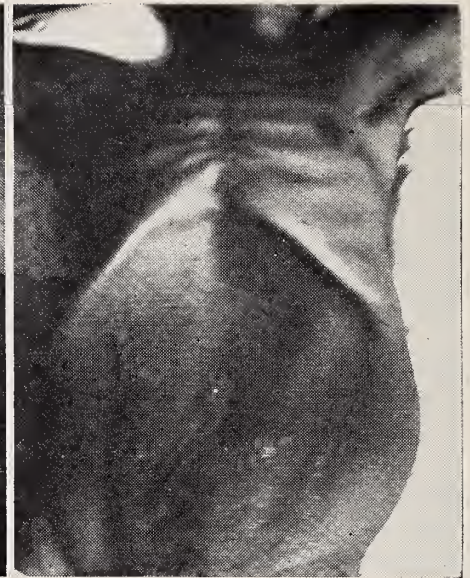


Figure 3

The appearance of the patient after paracentesis showing the shrunken abdomen with flaring of the ribs.

GROSS: The specimen consists of a thin-walled cyst measuring 51.0x39.0x11.0 cms. and containing 14,200 cc. of bloody fluid. On section there are several small pocket-like areas in the wall and several calcified areas.

MICROSCOPIC: The sections show marked thinning and congestion of the renal parenchyma with foci of scarring, tubular atrophy, and leucocyte infiltration; chiefly lymphocytes. A few glomeruli are hyalinized. Nearly all the tubules which remain are dilated and contain a reticulated pink coagulum within the lumens. The wall of the renal pelvis is quite prominent and about the same thickness as the renal parenchyma.

DIAGNOSIS: Hydronephrosis, left kidney.

We were thus able to definitely determine that this was a true hydronephrosis, which had held over 10 gallons, or nearly 40 liters of fluid.

DISCUSSION: In the individual with abdominal fluid in whom the etiology is obscure, or not well established, a urological work-up is imperative. In this particular case, cirrhosis, nephrosis, and rheumatic heart disease had to be considered in the differential diagnosis.

Summary

1. The problem of fluid in the abdomen presents a challenge in differential diagnosis.
2. Massive hydronephrosis must be considered in an ascitic abdomen.
3. An unusual case of massive hydronephrosis containing 10 gallons is recorded.

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New Members of the M. A. G.

Name	Address	County Society	Classification
Waddell Barnes	781 Spring St., Macon	Bibb	Active
Ralph G. Newton, Jr.	654 First St., Macon	Bibb	Active
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James P. Capo	Batthey State Hospital, Rome	Floyd	Active
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William W. Walker, III	Ga. Baptist Hospital, Atlanta	Fulton	Associate

Diverse Usage of Chlorpromazine in Clinical Practice

SARAH L. CLARK, M.D., and WILLIAM E. BARFIELD, M.D., Augusta, Ga.

CLINICAL INTEREST in the new drug, chlorpromazine*, was aroused by the work of Laborit.¹ He developed a technique for producing artificial hibernation and also used the drug to facilitate anesthesia in surgery. He found chlorpromazine a useful adjunct in controlling the pain of childbirth.

Pharmacological studies by Courvoisier and others²⁻⁶ have shown that chlorpromazine possesses a wide spectrum of activity. It is a central and autonomic nervous system depressant; blocks apomorphine-induced emesis in dogs; antagonizes motion sickness in dogs; and augments the action of alcohol, hypnotics, analgesics, anesthetics, and curare-like compounds. It can cause hypothermia and hypotension, and it possesses slight adrenolytic, antispasmodic, and antihistamine activity. The pressor response following central vagal stimulation is unaltered by the drug. There appear to be no renal or hematopoietic disturbances produced by its usage. A few cases of reversible obstructive jaundice have occurred in man.

Extensive clinical studies by Friend and Cummins⁷⁻⁹ and Kent et al.¹⁰ have conclusively shown that chlorpromazine is effective in controlling nausea and vomiting due to a variety of drugs, diseases, pregnancy, and irradiation sickness. It has been used successfully with disulfiram (Antabuse) in managing the withdrawal symptoms of alcoholism⁹ and as a sedative in the treatment of acute alcoholism.¹¹

Lehmann and Hanrahan¹² and, more recently, Winkelman¹³ have reported the effectiveness of chlorpromazine in the symptomatic treatment of neuropsychiatric disorders such as anxiety, agitation, obsessions, phobias, and paranoid psychosis.

Chlorpromazine has proved a definite aid in the relief of pain, nausea, vomiting, cough, and dyspnea associated with malignant lesions, resulting in improvement in appetite, strength, sleep, and well-being. In many instances the narcotic requirements can be reduced.¹⁴⁻¹⁵

Investigators in Europe and Canada have found that when chlorpromazine is used as a pre-operative medication, the anesthesia requirements and post-operative narcotic requirements are reduced. Because of its hypothermic effect, it has been employed in surgery to produce artificial hibernation.¹⁶⁻¹⁹

Chlorpromazine has proved to be a valuable adjunct in the management of labor with no ill effect on the fetus. It appears to be a pharmacologic antagonist to the scopolamine-induced psychomotor hyperactivity of obstetric labor.²⁰

Materials and Methods

In this study the value of chlorpromazine as an anti-emetic, sedative, analgesic, antispasmodic, and neuropsychiatric agent was appraised. Cases consisted of 78 adults, who ranged in age from 13 to 87 years, with medical, obstetrical, and gynecological disorders.

Chlorpromazine was given orally in 10 mg., 25 mg., and 50 mg. doses and intramuscularly in 12.5 mg., 25 mg., and 50 mg. doses as frequently as necessary to control symptoms, i.e. every four to eight hours. The therapeutic effectiveness of the oral versus the intramuscular route was compared.

Therapeutic response was reported as excellent, good, fair, and poor. Patients were observed for side effects such as hypotension, dizziness, dryness of the mouth, dermatitis, palpitations, hematological, hepatic, and renal dysfunction.

Results

A. NAUSEA AND VOMITING

Good to excellent results were obtained in three patients receiving nitrogen mustard therapy. It was found that nausea and vomiting could be completely prevented if 25 mg. were given intramuscularly one hour before and two to three and five hours after intravenous nitrogen mustard.

Chlorpromazine is the most effective anti-emetic we have yet used in the management of uremia. Seven out of 10 patients received fair to excellent results, only the terminal cases failed to respond. The dosage of 25 mg. intramuscularly every four to six hours appeared to be the optimal dosage. Beneficial sedation was also achieved in several instances.

Fourteen cases with nausea and vomiting of pregnancy were treated with chlorpromazine. Only 30-40

*Originally developed as 4560 R.P. by the Rhone-Poulenc-Specia Laboratories in France. Known as 'Largactil' in France, Canada, England, and Italy; as 'Megaphen' in Germany; and as 'Thorazine' (S.K.F. 2601-A) in the United States.

From the Department of Medicine and the Department of Endocrinology, Medical College of Georgia, Augusta, Ga.

The supplies of 'Thorazine' used in this study were provided by Smith, Kline and French Laboratories, Philadelphia, Pa.

TABLE I
TREATMENT OF NAUSEA AND VOMITING WITH THORAZINE

Etiology of N & V	No. of Patients	Optimum Dose of Thorazine	Therapeutic Response				Side Effects
			Excel- lent	Good	Fair	Poor	
Nitrogen mustard	3	25 mg. IM	1	2			
Post-operative	1	25 mg. IM	1				
Acute glomerulonephritis	1	10 mg. IM	1				
Chronic lymphatic leukemia	1	10 mg. IM 10-25 mg. p.o.	1				Reduced morphine requirement
Myocardial infarction	1	25 mg. IM		1			Some sedation
Lymphosarcoma with jaundice	1	25mg. p.o.	1				Marked sedation
Hypersplenism	1	10 mg. p.o. & IM	1				
Pregnancy	15	10-50 mg. p.o. & IM		2	8	5	Fainting, drowsiness, weakness, fatigue
Uremia	9	25 mg. IM	2	1	3	4	Sedation
Functional bowel distress	3	25 mg. p.o.		2	1		Weakness
Premenstrual tension	2	10-25 mg. p.o.	1	1			Relaxation, calming effect
Menopausal syndrome	1	25 mg. IM		1			
Acute myelogenous leukemia	1	20 mg. p.o. 50 mg. p.o. & IM		1			Reduced morphine requirements. Drowsiness, massive urticaria
Psychoneurosis	1	25 mg. IM		1			
Poliomyelitis	1	25 mg. p.o.		1			Dryness of mouth
Amebic hepatitis	1	25 mg. p.o.		1			
Rheumatic heart disease with hepatic congestion	1	10-20 mg. p.o.		1			
Digitalis intoxication	2	25 mg. IM		2			Drowsiness
Diverticulitis	1	10 mg. p.o.		1			
Multiple peptic ulcers	1	25 mg. IM		1			Drowsiness
Acute gastritis plus schizophrenia	1	25 mg. IM			1		Slight sedation
Haverhill fever	1	25 mg. IM		1			
Infectious diarrhea	1	25 mg. IM		1			
Idiopathic	1	10 mg. p.o.		1			

per cent received good to excellent results. Several patients in whom the nausea and vomiting were relieved developed hypotensive episodes with palpitations and tachycardia, which required discontinuation of the drug. Some patients who failed to respond to chlorpromazine obtained relief with pyridoxine. In our experience this drug offers no superiority over Dramamine or pyridoxine in the management of hyperemesis gravidarum.

Chlorpromazine proved very satisfactory in treating nausea and vomiting associated with leukemia, hypersplenism, lymphosarcoma, cardiovascular disorders, digitalis intoxication, gastro-intestinal disorders, infections, and post-anesthesia reaction. Hiccoughs were partially relieved in one patient with coronary insufficiency and myocardial infarction who was suffering from nausea.

B. MISCELLANEOUS USES OF CHLORPROMAZINE

Of particular interest was the immediate relief of dysmenorrhea in two cases. Also, the drug exerted a calming, sedative effect in two cases of premenstrual tension.

Chlorpromazine gave gratifying results in neuropsychiatric conditions such as tremors, somatization reactions, anxiety, functional bowel distress, and mild agitation, and was helpful in relieving the mental symptoms of the menopausal syndrome. The drug exerted a calming, quieting effect and relieved restlessness.

A colored female with schizophrenia, in addition to far advanced pulmonary tuberculosis, was greatly benefited by 50 mg. chlorpromazine intramuscularly every eight hours. She suffered from paranoid de-

lusions and hallucinations. Chlorpromazine relieved her agitation somewhat, and she was less concerned about the voices she heard. Withdrawal of the drug on two occasions caused a relapse into the catatonic state.

Chlorpromazine proved useful as a sedative in hypertensive encephalopathy, premedication for proctoscopy, one case of erythema multiforme bullosum, functional hypoglycemia, senile arteriosclerosis, and one case of sickle cell anemia with leg ulcer and associated cramps. One young colored male with diffuse toxic goitre received a greater amount of sedation from 50 mg. chlorpromazine given intramuscularly at bedtime than from one and one half grains Nembutal® orally.

A colored male with acute bacterial meningoencephalitis and Jacksonian convulsions received additional sedation and convulsion suppressing effect when chlorpromazine was added to sodium luminal therapy.

It was possible to reduce the morphine dosage in a white female who was being treated with chlorpro-

mazine for severe nausea of acute myelogenous leukemia.

Side Effects and Optimal Dosage

Principal side effects observed were drowsiness, dizziness, palpitations, dryness of mouth, and hypotensive episodes.* Severe allergic dermatitis with urticaria occurred in one instance. Local reaction at the site of injection occurred if the drug were not given deep in the muscle.

More pronounced therapeutic effect was noted from the intramuscular route of administration. In the hospitalized patient the parenteral route was generally preferable. Hypotensive episodes tended to be more common in ambulatory patients, so generally in those cases smaller dosage and oral therapy whenever possible was preferable. In pernicious nausea and vomiting 25-50 mg. intramuscularly initially was more efficacious, with transfer to the oral route of administration when feasible.

*Several ambulatory patients experienced a "fainting spell" 10 to 30 minutes after intramuscular injection of the drug. It is best that patients rest in the recumbent position for one hour after such therapy.

TABLE II
OTHER THERAPEUTIC USAGES OF THORAZINE

Indication	No. of Patients	Optimum Dose of Thorazine	Therapeutic Response				Side Effects
			Excel- lent	Good	Fair	Poor	
Hypertensive encephalopathy	2	25 mg. IM		2			Reduced dizziness and headache. Sedation moderate-hypotensive effect.
Premedication prior to proctoscopic	(a) 2 (b) 1	50 mg. IM 25 mg. IM		2		1	Marked drowsiness, no hypotension
Paranoid schizophrenia	1	50 mg. IM		1			Sedation and less psychomotor agitation but hallucinations persisted.
Sedation for sicklelemla patient with foot cramps	1	25 mg. IM		1			Sedation
Senile arteriosclerosis with restlessness and disorientation	2	25 mg. IM			1	1	Slight sedation
Diffuse toxic goitre with restlessness	1	50 mg. IM		1			Good sedation
Psychosis from ACTH injection for Stevens-Johnson syndrome	1	25 mg. IM				1	
Hypoglycemia with restlessness and insomnia	1	25 mg. IM		1			Sedation
Multiple sclerosis with dizziness and insomnia	1	25 mg. PO		1			Sedation; more cheerful
Hiccoughs and nausea from coronary insufficiency and congestive failure	1	25 mg. IM		1			
Stevens-Johnson syndrome with restlessness from lesions	1	25 mg. PO			1		Sedation
Anxiety tension state with hysteria	1	25 mg. PO	1				
Dysmenorrhea	1 1	50 mg. IM 25 mg. IM	1 1				Pain relief Pain relief
Migraine headaches, palpitations	1	25 mg. IM				1	
Menopausal syndrome, depression	1	25 mg. IM			1		
Somatization reaction	1	25 mg. IM			1		

Summary and Conclusions

Chlorpromazine has been used in the treatment of 78 adult patients suffering from a variety of diseases. It proved of definite value as an anti-emetic, sedative, analgesic, and as an agent in controlling the symptoms of certain neuropsychiatric disorders. Its beneficial effects appear to be mediated largely by central nervous system depression.

One must be certain of the clinical diagnosis before employing chlorpromazine, as it may mask important clinical signs and symptoms. The drug must be used cautiously and in lower dosage in the ambulatory patient due to the possibility of hypotension. The dosage of sedatives and narcotics must be reduced when used in conjunction with chlorpromazine, since it appears to potentiate their action.

Many intriguing possibilities are apparent for the use of chlorpromazine in medicine, obstetrics, gynecology, surgery, and anesthesia. More intensive clinical research is warranted.

Medical College of Georgia

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Relation of Radiation to Surgery in Cancer of the Breast

HAROLD W. JACOX, M.D., New York, N. Y.

CANCER OF THE BREAST is one of the most treacherous of all neoplasms because of the ease and rapidity with which it gets into the lymphatics or blood stream. There is no known method of determining definitely the prognosis in any individual case either before or at the time of operation. A study of long term survival rates shows that local recurrence or metastatic lesions may occur 15 or more years after the operation. In a series of more than 4,600 patients from the Mayo Clinic,⁵ 64 per cent (or almost two-thirds) had axillary nodal metastases at operation. Of these, 12 per cent lived 15 or more years, and of the 36 per cent who did not have positive axillary nodes, 48 per cent lived 15 or more years. This shows the prognostic importance of spread of the disease to the axilla at the time of operation.

I believe that cancer of the breast is primarily a surgical problem and that the treatment of choice is complete surgical removal of the primary tumor and regional lymph nodes in one block, because this offers a woman the best chance of cure. Now greater care is being used in selecting patients for this radical procedure, and more intercostal, supraclavicular, and occasional iliac bone biopsies are being done. If any of these are positive the patients are treated entirely by irradiation at our institution.

The results of treatment vary with the degree of malignancy of the tumor, with the involvement of the nodes in the axilla, and with the length of time the patient waited before being operated upon. Undoubtedly the most important prognostic factor is the clinical extent of the disease at the time the patient first comes for treatment.

The effect upon prognosis of extent of involvement when treatment is instituted has been demonstrated repeatedly. Haagensen¹ reports that five year survival occurred in 47.2 per cent and 38.6 per cent of patients without and with metastases when data were calculated on the basis of all patients having carcinoma of the breast seen during the period of study, and in 58.2 and 48.7 per cent, respectively, of the patients undergoing mastectomy.

In general, the histologic type of tumor present in

breast tissue is of lesser importance in prognosis than grading or staging alone. The grade of the tumor and the state of the axillary lymph nodes give a more accurate prognosis than grading or staging alone. Goldfeder,³ an experimentalist at the Delafield Hospital in New York City, has demonstrated that growth rate, radiosensitivity, and metabolic activity differed considerably in two animal mammary tumors which were almost identical histologically. Many pathologists and radiologists have noted that the response of breast carcinoma to irradiation is not consistently related to histologic type.

A re-evaluation of prognostic factors is necessary because two divergent view points have developed concerning the best therapy for this condition. In the United States, emphasis has been placed upon eliminating the neoplasm by radical excision of as much potential tumor tissue as possible. In Great Britain irradiation has been stressed as an adjunct to simple mastectomy with particular attention to intensive roentgen treatment outside the area of the operative field.

In 1948 McWhirter,⁸ of the Royal Infirmary of Edinburgh, pointed out the importance of group analysis. He said that the worth of any method of treatment of cancer should depend as much on the number of cases to which it will apply as on the results obtained when it is applied. Patients who are too far advanced for a radical mastectomy are referred for palliative X-ray therapy; but the fact that these patients were treated by X-rays and not by radical operation does not justify their exclusion from the total series or their being counted as other than a failure of surgery.

He maintains that results derived from the data of all breast cancer patients appearing for treatment in a large general hospital have a greater validity than results based upon series of cases in special hospitals or from a single surgeon, since data in either of the latter series usually are weighted in the direction of favorable results because of the automatic pre-selection of patients as influenced by the specialty of the hospital or surgeon.

He also says that criteria for classification of breast cancer patients unjustifiably affect results. A

shift in the classification of moderately advanced cases from Stage I to Stage II will improve the results in both Stage I and Stage II. That such improvement is based upon classification, rather than upon therapy, is obvious when the data are examined. The removal of moderately advanced cases from less severe cases in Stage II dilutes the latter with more favorable cases and thus increases the percentage of survival in Stage II. Too often comparisons are considered valid, when in reality the conclusions have been based upon results obtained with two entirely different patient groups.

These worthy criticisms of McWhirter are encouraging careful scrutiny of data and conclusions, and he should be commended for his vigorous presentation of his thesis.

Today there is not even the same agreement on general treatment policy which was apparent some 15 or more years ago. The data of Daland² are usually included as background material in any discussion of treatment in breast cancer. He reported a series of 100 consecutive untreated cases, 40 of whom lived more than three years, 22 more than five years, nine more than seven years, and five more than 10 years.

In October 1950, Taylor and Wallace¹¹ reported the ninth group from the Massachusetts General Hospital, in a series of patients with breast carcinoma, the first of which covered the years 1894-1904. The authors commented that the most significant fact in their data was the improvement in results, each succeeding group faring better than the earlier groups. In the first group, five year cures were obtained in 19 per cent, while 51 per cent of the last group were living without recurrences for at least five years. The factors chiefly responsible for this improvement appeared to be earlier and better recognition of breast cancer, more careful selection of patients submitted to surgery, and better operative technics. They found that the criteria of operability, established for the first series, had been adequately confirmed by experience; and an unfavorable prognosis depended upon: adherence of the tumor to skin or chest wall, ulceration with skin involvement, grossly enlarged axillary lymph nodes, palpable supraclavicular nodes, bilateral involvement, and pregnancy or lactation. Of indeterminate significance were: the quadrant in which the tumor arose; age, although rapid tumor growth and higher malignancy tended to occur somewhat more frequently in younger women; duration, although important to an individual; and type, which is of lesser importance than the degree of malignancy. Large tumors can occur in the breast without any metastatic involvement, but it eventually occurs. They too found that prognosis was affected most by the extent of axillary

involvement and the degree of malignancy. "Cures" for the entire series were 33 and 77 per cent for those with and without axillary extension; and 41 and 79 per cent for individuals in the ninth group.

A number of authorities have suggested that in most cases a radical dissection is preferable to simple excision of a breast. The more extensive procedure usually is indicated to safeguard the patient because clinical appraisal of axillary metastases is notoriously inaccurate. Even small cancers may metastasize, often without palpable manifestation. Saphir and Amromin,¹⁰ pathologists of Chicago, showed that in restudy of specimens previously reported to be without axillary involvement, 33 per cent had metastatic carcinoma demonstrable in numerous re-cut serial sections.

The effect of irradiation upon lymph node metastases assumes greater importance with new evidence of the frequency of involvement of the internal mammary chain. Williams and Cunningham,¹² of St. Bartholomew's Hospital in London, found that cancer cells had been completely destroyed in irradiated breast or lymph nodes in one of 17 cases. Lumb,⁶ of the Westminster Hospital of London, reported complete destruction in seven of 60 irradiated patients and in four of 11 who received more than 3,500 r in 20 to 40 days. Experimental evidence indicates that 3,750 r in 18 days as advocated by McWhirter is biologically more effective than 5,500 r in 90 days as reported by Lenz.⁷

Conflicting views have been expressed on the role of radiation therapy in the management of mammary carcinoma. All workers agree that radiation may be of sole value in the treatment of advanced cases considered or found to be inoperable, and in cases of recurrence postoperatively. The conflict arises about the value of irradiation as an adjunct to (either pre- or postoperative) or as a substitute for mastectomy.

In a series of 135 patients of all stages treated preoperatively by Ash and Peters¹ with a modified McWhirter technic at the Toronto General Hospital, 24 to 18 per cent showed pathology negative for neoplasm at the time of surgery following a previous biopsy positive for cancer. Of 92 patients who had radical mastectomies after preoperative irradiation, 45 had grossly enlarged axillary lymph nodes upon admission; 21 of these 45 (or almost half of them) had negative pathologic findings at operation. The value of irradiation in this series is evident when one considers too that the local recurrence rate was only about 12 per cent among 80 per cent of advanced stages of the primary lesions. These results speak for themselves.

McWhirter has reported in several journals and in talks in this country and elsewhere that simple mastectomy plus thorough irradiation gives better results

than can be obtained with radical operations. His 1950 report gives the five year survival rates for patients treated in the years 1941 to 1945 inclusive as: with axillary metastases, 44 per cent; no axillary metastasis, 89 per cent; too far advanced locally for radical mastectomy, 29 per cent; with evidence of distant metastasis, none. The over-all five year survival rate for all cases, treated or untreated, was 43.7 per cent; and for all cases having no evidence of distant metastasis 50.5 per cent.

McWhirter describes improved results as a chief reason for advocating heavy irradiation following simple mastectomy as a substitute for radical surgery. However, his argument is weakened by his own data which indicates that local recurrences developed in 39 per cent of his patients. It is now recognized that with improvements in surgical technics now being used only about 10 per cent of radical mastectomy cases have local recurrence at the operative site.

In the Edinburgh experiment of McWhirter the following principles of treatment are essential:

1. The axillary and supraclavicular lymph nodes must be treated as one continuous chain by two opposing rectangular fields.
2. The internal mammary nodes must be treated in continuity with the chest wall with the central ray tangential to it and the opposing ports about 16 cm. apart.
3. Hard quality radiation of 3.7 mm. Cu. half value layer is advisable.
4. Adequate exposure to a minimum tumor dosage of 3,750 r in three weeks is necessary.
5. Only one course of treatment is given beginning about two weeks post-operatively and treating all four portals daily.

His five year survival rate of 43.7 per cent compares favorably with Haagensen's 47.7 per cent for radical mastectomy, but it must be remembered that

he reports only strict survivals and not freedom from clinical disease.

Summary

In summary then, radiation therapy is a valuable adjunct to radical mastectomy in those patients who have a microscopically proved infiltrating tumor or axillary metastases. It may be of real benefit when used to supplement simple mastectomy. It is helpful in the inoperable cases of breast cancer and in those with recurrences after mastectomy. Radiation should not be used routinely as a prophylactic measure, but in any case it should be evaluated in relation to the individual situation.

*The Presbyterian Hospital
622 West 168th Street*

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AMA Surveys County Medical Societies

TO FIND OUT WHAT county medical societies throughout the country are doing and to help them develop new public service programs, the AMA's Council on Medical Service currently is distributing questionnaires to officers of the 1,911 county and district medical societies in the U. S. The most complete of its type ever undertaken, this survey covers all major areas of society interest—including meetings, committees, programs and activities, insurance programs, dues, office facilities, and personnel. Since

this is the only way that the Association can keep abreast of society activities, the Council hopes that all questionnaires will be returned as soon as possible. The information gleaned from these reports will be invaluable aids to societies seeking assistance in expanding their activities and will help the Council's staff increase its ability to be of service to society officers and members. This year's survey is being conducted in cooperation with the Department of Public Relations.

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So Your Town Wants a Doctor*



THIS BROCHURE is sponsored by the Council on Rural Health in cooperation with the Medical Association of Georgia. The purpose of this brochure is to assist communities in their efforts to secure a resident physician. The ideas and suggestions embodied in the following paragraphs are the results of interviews with many young graduates and interns as to what a young physician considers in selecting a location in which to practice medicine. It is the sincere hope of the Council that in the future there will be a better distribution of physicians in the rural areas.

However, this can be accomplished only by each individual community acting as a unit in assuming the responsibility of making its town an attractive place in which to live and practice medicine.

The young physician, in considering a town or location in which to practice, primarily has in mind three very important questions:

1. Can I practice there the type and quality of medicine I have been trained to practice?
2. Will I enjoy living and rearing my children in that community?
3. Will there be sufficient income to assure me and my family a decent living?

The young physician who has recently completed his education is well aware of the fact that he must consider the facilities available to him in his chosen community. Having spent many years and a small fortune in securing his education and medical training, he would never be content to locate in any community where a lack of facilities or cooperation on the part of its citizens would result in his having to practice an inferior type of medicine.

During the past 25 years there has been a tendency to over-specialization among medical students, and this has resulted in the general practitioner or family doctor becoming almost extinct. During the past few years, however, the pendulum has started

swinging in the opposite direction, and the general practitioner is again coming into his own as an integral part of the community. Working hand in hand with the specialist and taking care of 90 per cent of the ills of the community, he becomes a partner and leader in the social, religious, economic, and civic life of the community. In turn he expects the community to assist him in providing the proper facilities for the diagnosis and care of the ill.

Without proper facilities a physician must refer most of his seriously ill patients to other physicians or hospitals in nearby communities in order to make a proper diagnosis or to get proper treatment for them. This results in a situation whereby the fees which should be his go to physicians in other localities while he can only do the work of minor cases and first aid. In time this causes the young doctor to become no more than a reference bureau, a person to make night calls, or a convenience to his patients when they can't go somewhere else.

A good physician is aggressive and enterprising and does not expect to have the world handed to him on a silver platter, but he does need the help of the community in establishing and making work a scientific and up-to-date practice. He is more or less a perfectionist and realizes his responsibility for human life. He is not willing to do things in a sloppy way, and he strives to give his best in service and ability. He is really afraid of inadequate equipment, the lack of nursing care, and the absence of specialists whom he will need for consultation in cases beyond his scope of training.

Being the only physician in the community has many disadvantages. Not only does he need other doctors for consultation, but he also needs them for relief. A doctor who has to practice medicine every day of the week, every week of the year will not be able to stand the strain either physically or mentally. He does not have the opportunity to attend meetings, take post-graduate work or other professional courses. He needs a community where other doctors will be available for help when he needs them.

Many communities are constantly clamoring for

*(This material is being sent, in booklet form, by the Rural Health Committee of the Medical Association of Georgia to all towns seeking physicians. We feel that this committee is performing a valuable service and deserves the cooperation and support of all members. Ed.)

doctors; yet they have made no concentrated effort to provide the proper facilities and have made no preparation for securing or keeping one. No community would dare call a pastor for its church without first securing a home in which he would live or a church in which he would preach. Many communities also provide homes for their teachers. Yet in states all over the nation communities are daily requesting doctors without making provision for a home or office space, much less a clinic or hospital. Is it any wonder then that these communities are not able to attract or to keep a physician?

Since the lack of physical facilities is an acute problem, many communities will want to know how this can be remedied. The young physician just out of college will not have the money to set up an office or clinic unless the community helps him. This financial aid may be in the form of an outright gift of office space and equipment, a loan with long-term interest, or a clinic erected and maintained by tax money obtained through bond issues. This will assure the physician that the community really wants a doctor and is willing to pay the price in effort and money.

In turn the business leaders of the community will profit in more than one way from this investment in a doctor. In addition to having a doctor when he is needed, they will also profit financially. When people go to another locality for their medical aid, they will spend money in that locality. Then, too, new families and new business will not come into a doctorless town. It is fact that both the physician and the community will profit from a cooperative effort to provide the physical facilities needed.

The second question asked by the young physician in seeking a location in which to practice is a personal one which is very important to him and his family. He will want to know whether he will enjoy living and rearing his family in that community. He is interested in a well-rounded social, civic, educational, and religious life for himself and his children. He himself is a well educated man and he will not be content to have his children attend sub-standard schools. Fortunately, the civic and social life in the smaller towns offers greater opportunity for pleasure and service than does that in urban areas. Since no doctor wants to resign himself completely to the practice of medicine, he should be made aware of the opportunities available for recreation, rest, civic participation, and religious affairs. To sum it up briefly, he wants to know whether the community offers an environment which promotes a happy and adequate life, good schools, churches, active civic clubs, and recreational facilities.

The third question asked by the young doctor is one that is asked by men everywhere, "Will I be

able to make a living for myself and my family in this community?" The physician is no different from others in seeking financial security. The chief aim of any doctor is to serve humanity gladly and freely, but at the same time he expects a decent income to support himself and family and often to pay up the money he has had to borrow to complete his medical education. The estimated cost for the average young doctor to complete a medical education is \$15,000, so, many will certainly be in debt when they begin their first practice.

Physicians are professional men, and most communities expect their professional men to maintain a high standard of living. They are expected to dress well, drive a good car, live in a nice house, send their children to college and at the same time keep up an up-to-date, well-equipped office. The community expects the best of service and no doctor can give this unless he has a well-trained staff. All of this costs money so the community must offer its prospective doctor economic security.

At one time small communities supported several doctors, but due to better roads, better cars, and the idea that it is stylish to go to the larger cities for medical care, many communities today are not able to support one doctor. Unless the wealthy and better class of people are willing to cooperate with the other members of the community in having the local doctor and leaving it up to him to decide when outside help is needed for consultation, they will never be able to obtain or keep a doctor in their own community.

Now that the community knows what the young physician expects from his chosen location, the next question concerns the method of obtaining a doctor. First the people must get together and make definite plans for making their community attractive for doctors. They must be able to present an outlined and detailed plan showing exactly what they are prepared to do both financially and cooperatively, and if possible, they should have their program started before applying for a physician.

If the local group is willing to do this, there is no doubt that in time it will be able to obtain a good physician either through its state medical association or through the placement offices of the various medical colleges in its section of the country. There are doctors available for the right communities.

PREPARED AND PUBLISHED BY
MEDICAL ASSOCIATION OF GEORGIA
COMMITTEE ON RURAL HEALTH

If further inquiry please write
Committee on Rural Health
Medical Association of Georgia
875 West Peachtree Street
Atlanta 9, Georgia
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Score Sheet

1. Do you have available office space and local hospital facilities?
2. Are hospital facilities available in nearby towns?
3. Do you have proper housing facilities for the physician?
4. Is your town and trade area able to support a physician?
5. Are your citizens cooperative in wanting a physician?
6. Does your community offer good recreational facilities?
7. Do you have good schools and churches?
8. Does your town show a progressive spirit?
9. Are your civic clubs active?

10. Do you have good roads?

Allow 10 points for each question answered yes.

Allow five points for each question answered no.

Score of 70 or above—Should be able to get a physician.

Score from 50 to 70—Doubtful.

Score below 50—Organize and get situation in hand or you may never be able to attract a physician to your community.

For further information write to:

Physician Placement Service
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"The Physician as a Citizen"

THE MAN WHO ACQUIRES an M.D. degree is no more and no less a man than he was before he became a physician. Special privileges and automatic prestige may tempt the M.D. to consider himself a person somewhat apart, but the man behind the M.D. degree is also a citizen, member of a community, family man, and individual. J. P. Price (J.A.M.A. 157:433, 1955) discusses responsibilities that should not be evaded by the physician.

Being a citizen involves duties and obligations in addition to rights and privileges. The physician is well qualified to perform as a citizen because of his education, experience in logical thinking, and opportunity for intimate knowledge of human problems.

To plead absorption in personal concerns is not sufficient excuse for refusing the role of advisor and leader. A physician should vote, participate in programs for better government, support efforts to deal effectively with crime and corruption, and in general, take an active part in local and national politics, even to the extent of becoming a candidate for office himself.

As a member of a community, the physician should share in its life. Three fields which might well be his special concern are education, child welfare, and charitable organizations. Concerning the school system, the physician should be aware of the character of the teachers employed, health safeguards, the emphasis placed on character and good sportsmanship, and whether the textbooks employed are free of hints of communism or atheism.

Boy Scouts, Girl Scouts, the Y.M.C.A., and youth

groups in churches and athletic leagues are organizations in which the physician can express his interest in young people. A contribution in time and leadership is part of the responsibility of the physician. This is also true in the field of philanthropy, an area in which the physician is in a unique position to be useful.

A community consists of homes, and it is the home that determines the basic health of society. A home should be the focus of the family, a place where each member of the family is made to feel both an individual and an integral member of a group. The physician's role in the home is that of any father: to foster mutual play, work, and discussion; to direct and lead his children; to give his children the security of belonging, of being wanted and loved.

The fourth area in which the physician must function as a person is the spiritual. Spiritual disease is more prevalent than physical or mental illness; the symptoms are easily seen in moral laxness, in alcoholism, in dishonesty and crime, in the attractiveness of atheistic communism to some persons. Physicians, to judge from the many complaints concerning financial reward's being put ahead of service, are not free of moral laxness. It is the author's opinion that, "The greatest need of our country today, and of our profession, is spiritual rebirth a return to God and to His eternal principles. And the rebirth must come in the heart of the average citizen, and of the average doctor of medicine."

(Reprinted from the *Cedartown Standard*)

PATHOGENESIS OF RETROLENTAL FIBROPLASIA

THE RECENT OBSERVATIONS on the pathogenesis of retrolental fibroplasia are of extreme practical importance. Although independent initial reports correlating the inhalation of high oxygen concentrations in newborn premature infants with an increased incidence of retrolental fibroplasia were published by Crosse, Campbell, and Patz as early as 1952, many well equipped hospitals within the state continue the use of excessive oxygen in the care of these infants. It is unfortunate that such a temporal hiatus frequently exists between basic fundamental observations and practical patient care.

Because of its timeliness, the *Journal of the Medical Association of Georgia* is reprinting in this issue (beginning on page 417) a report of the Maryland Committee on Maternal and Child Welfare which appeared in the *Maryland State Medical Journal* in February of this year. It is recommended reading for all.

DOCTORS, BLOOD BANKS, HOSPITALS, CIVIL DEFENSE

RECENT EXPERIENCES WITH local disasters in planning for civil defense emergencies demonstrate conclusively that there will be an inevitable time lag before national aid can be delivered to any disaster point. Lives saved and suffering alleviated immediately following a disaster will be directly proportional to effective immobilization of community and state resources. Doctors, hospitals, and related services should be acquainted with current plans.

The place of whole blood in the management of trauma is obvious. The immediate supply of whole blood will be largely dependent upon the blood banks of the state. Each blood bank has been requested to assume a quota equivalent to the normal amount used in a month. This quota will be made available during the first 24 hours of a disaster.

In order to effect speedy notification of the amount of blood required and the point of delivery, each district will have a doctor designated to notify the blood banks in his district.

Most blood banks are using standard commercial sets which are interchangeable, and recipient sets which are likewise interchangeable. Blood in a bottle which cannot be used at the site of need is of no

value. It is recommended that each blood bank keep in stock three months supply of standard collection bottles and sets to be used in event of emergency need. The Red Cross is working on a plan to stockpile and rotate collecting bottles in each chapter visited by its mobile unit. Cooperation of the doctors in each community in training personnel to collect such blood is our responsibility.

The importance of each blood bank and Red Cross chapter of maintaining a file of available donors with name, address, phone number, and blood type is obvious.

Blood transfusion carries certain potential dangers; to minimize these hazards the adoption of minimal standards for blood banks and collecting centers is essential. A committee has drawn up such standards and these are being submitted to parent organizations for adoption. Here is an opportunity for organized medicine to help.

Blood must be delivered to the scene of disaster quickly and in a useable state. The Red Cross has developed disposable shipping containers. The transportation division of Civil Defense is planning their part in delivering this blood.

The amount of whole blood available immediately after a disaster will be woefully inadequate. Plasma expanders will help if they are on hand and if dispensing sets are available. Each hospital throughout the state can help by maintaining as large a reserve of these materials as practical. The State Civil Defense authorities are considering plans for dispersing any stockpile they may acquire throughout the hospitals of this state. This will require community cooperation.

The success of any state plan for minimizing damage to its citizens in event of civil or military disaster depends upon the information and organization of each community. Blood and plasma expanders are our responsibility.

HYPERTHYROIDISM-STATUS OF CURRENT THERAPY

IN EVALUATING THE STATUS of a patient with thyrotoxicosis and selecting a method of therapy, one must consider the changing concept of thyroid disease. Although its exact pathogenesis is still unknown, the disease is no longer regarded principally as one of the thyroid gland. In the future, patients with hyperthyroidism may not require surgery as they do today.

At present, thyrotoxicosis may be controlled effectively and safely by the following methods:

- (a) Prolonged administration of antithyroid drugs
- (b) Subtotal thyroidectomy
- (c) Treatment with radioactive Iodine(I_{131})

Factors which influence choice of treatment are diverse. The three most important ones, however, are: degree of thyrotoxicosis, character of the gland, and ability of the patient to tolerate surgery. Patients with mild thyrotoxicosis will respond to medical therapy, and some with severe manifestations will recover. Recent reports reveal many cures effected by the use of antithyroid drugs.

In some clinics approximately 50 per cent of the patients have been restored to normal thyroid function following administration of Tapazole in average daily doses of 60 mg. for 90 to 120 days. Tapazole is preferred to propylthiouracil because it is faster acting, requires a smaller dosage, and produces fewer toxic reactions.

Probably more than 90 per cent of all patients with thyrotoxicosis will respond to antithyroid drugs, but only one-half of them will likely remain stable. There is no way of predicting which ones these will be. Although the milder cases, with only moderate diffuse enlargement of the thyroid gland, are more likely to be cured, there are many exceptions.

When surgery is indicated the patient should be brought to euthyroidism by means of antithyroid drugs, and the operation should then be performed with anatomical dissection. This is the safe and preferred procedure. Under such circumstances, mortality is around 0.2 per cent and complications occur in only two per cent or less of the cases.

Patients who are refractory to antithyroid drugs, or in whom this therapy is contra-indicated for one reason or another, can be operated upon safely if corticotropin is administered for a few days pre-operatively and continued over the post-operative stress period.

A sharp distinction should be made between thyrotoxicosis with *diffuse* enlargement of the thyroid and *nodular* toxic goiter. None of the nodular goiters should be treated definitely with antithyroid drugs or Iodine $_{131}$. While they respond favorably, the total results are less striking than in Graves' Disease. Larger doses are necessary to control the disease, response is slower, and there is a corresponding increase in adverse drug reactions. Even when the other results are good, the hazards of nodular goiter remain, namely: tracheal compression or nerve pressure, unsightly deformity of the neck, and co-existing

thyroid cancer. In Georgia the incidence of cancer in single nodules has been found to be 12.5 per cent; in multinodular goiter, 1.6 per cent. Cancer was found in four per cent of 480 consecutive cases of thyroid disease. The incidence in the non-toxic cases was higher than the average, or seven per cent. However, only 72 per cent of the non-toxic goiters were treated surgically. If operative and pathologic diagnoses could have been obtained on the remaining 28 per cent, the incidence of cancer conceivably might have been found to be higher.

The treatment of thyrotoxicosis in nodular goiter is surgical. Response of patients is uniformly satisfactory and recurrence is rare.

Radioactive Iodine has been used largely for the treatment of thyroid cancer. In the treatment of thyrotoxicosis, it is usually reserved for cases in these special categories: (1) aged patients; (2) those with recurrent thyrotoxicosis; (3) those with severe concurrent disease; (4) those whose disease cannot be controlled by antithyroid drugs; and (5) those who refuse surgery.

It is quite possible that I_{131} will someday replace surgery in the treatment of thyrotoxicosis with diffuse hyperplasia and moderate sized glands. For the present, with our limited knowledge, it should not.

COUNTY MEDICAL SOCIETIES MERGE

NINE OF THE 80 component societies of the Medical Association of Georgia have been abolished in the last five months, and in their place have risen five strong organizations, all of them two-county or multi-county societies. In addition, plans are being discussed for the merger of seven other small societies into nearby larger and more active organizations.

Over the years, the grouping together of counties with only a few physicians has been a slow process. However, 1955 seems to be a banner year at the end of which we hope to be able to say that there is an active medical organization covering every section of the state.

Physicians of the five new multi-county organizations have taken steps to consolidate the small counties in their area because they have realized that a poor county society is as bad or worse than no organization at all. The comment has often been made "if we're going to have a society, let's have an active one." These physicians have taken the time and the trouble to form a society in their area where none existed before. The officers and councilors of the Association hereby welcome these new societies into the Association and wish them success in their future activities.

SO YOUR TOWN WANTS A DOCTOR

May 12—OCONEE VALLEY MEDICAL SOCIETY—(Hancock, Morgan, Greene, Taliaferro Counties)—J. Lee Parker Jr., Greensboro, President; George Green, Sparta, Secretary.

May 25—CHATTAHOOCHEE MEDICAL SOCIETY—(Forsyth and Gwinnett Counties)—Harry Hutchins, Buford, President; Fayette Sims, Lawrenceville, Secretary.

July 12—FLINT MEDICAL SOCIETY—(Dooly and Crisp Counties and probably Turner County)—C. E. McArthur, Cordele, President; Perry Busbee, Cordele, Secretary.

July 19—PEACH BELT MEDICAL SOCIETY—(Houston, Peach and Crawford Counties)—A. Smoak Marshall, Ft. Valley, President; E. Faxton Seay, Marshallville, Secretary.

The new organizations, in order to convey the idea that several counties are included in their jurisdiction, have adopted geographical names like "Oconee Valley," "Chattahoochee" and "Peach Belt."

The new societies are listed below with the date of merger and the counties included in the organization.

April 20—SOUTHEAST GEORGIA MEDICAL SOCIETY—(Treutlin, Toombs, Montgomery and Wheeler Counties)—J. E. Mercer, Vidalia, President; John D. McArthur, Lyons, Secretary.

THE COMMITTEE ON RURAL HEALTH is to be congratulated on the recent publication of its brochure entitled "So Your Town Wants a Doctor." This excellent pamphlet is being made available to all communities within the state which are seeking physicians. Many helpful suggestions are directed toward small communities which have thus far been unsuccessful in attracting and holding sufficient medical personnel. The viewpoints of both the prospective physician and the community without a doctor are brought into sharp focus. This publication should facilitate the solution of this ever pressing problem. A reprint of the pamphlet with its attractive cover is found on page 408 of this issue of the *Journal*.

Publication of this pamphlet represents only one such project undertaken by this very active committee. Their inauguration of a Senior Day program at the Medical College of Georgia and at Emory was a signal success.

Such increased activity by committees of the Medical Association of Georgia is becoming more and more apparent. It reflects the wise selection of committee workers and a new awareness of the members over the state of their stake in the Association.

Census of Foreign Exchangees

ALMOST 40,000 FOREIGN STUDENTS, scholars, and doctors spent the 1954-55 academic year in the United States, according to *Open Doors*, the annual census of foreign exchangees in the United States, published by the Institute of International Education.

The report gives data on the 34,232 students from abroad who studied in the U. S. this last year, on 635 scholars on the faculties of U. S. educational institutions, and on 5,036 foreign doctors training as interns or residents in U. S. hospitals.

Five thousand thirty-six physicians from 84 countries trained in American hospitals, approved by the AMA for internships and/or residencies, as interns or residents, according to the results of the survey.

Over a quarter of the visiting doctors came from Far Eastern countries. Latin Americans and Europeans each represented about one-quarter of the total. Canadians and Near and Middle Easterners constituted smaller groups, and very small numbers came from Africa and Oceania. Citizens of 10 countries comprised two-thirds of the total: the Philip-

pinas, China, India, and Korea in Asia; Turkey in the Near East; Germany and Italy in Europe; Mexico, Cuba, and Canada in the Western Hemisphere.

Three thousand two hundred seventy-five or 65 per cent of all the foreign doctors took advanced training with resident status, and 1,761 were interns. Among the doctors from Canada and the Near and Middle East an unusually high proportion were residents; the European doctors, on the other hand, included a high percentage of interns.

In tabulating the residents' medical specialties, it was found that the two largest groups were in general surgery (663) and general medicine (506).

The foreign doctors were found to be training in 42 states, the District of Columbia, Puerto Rico, Hawaii, and the Canal Zone. An extremely large group (1,186 or almost 25 per cent of the total) was concentrated in the state of New York. Other states having sizable numbers of foreign physicians were Ohio, Massachusetts, Illinois, New Jersey, Pennsylvania, Missouri, Michigan, Maryland, and California in that order.

abstracts by georgia authors



Chambers, William R., 101 Third Street, N. E., Atlanta, Ga. "The Headache of Intracranial Aneurysm", J.M.A. Ala. 24:193-197 (Feb.) 1955.

While no headache may be present in cases of intracranial aneurysm until subarachnoid hemorrhage has taken place, many do present the premonitory symptom of headache and often of a characteristic type. In brief, it might be said that any half-head headache somewhat resembling migraine which first appears after age 40, or any "migraine" which suddenly changes severity, position or character should be suspect. Especially characteristic is a boring pain behind one eye with diplopia, photophobia or other eye signs.

Since somewhere between 30 and 50 per cent of subarachnoid hemorrhage cases die in the first attack, it would be highly desirable to suspect and diagnose the condition before subarachnoid hemorrhage has occurred. Although ophthalmoplegic migraine can occur without the presence of aneurysm, a large percentage of such cases are associated with aneurysm. Carotid angiogram is now advanced to the point where it gives excellent proof of aneurysm in most instances, as well as localization thereof. In competent hands, it is proved reasonably safe. In addition, modern anaesthetic and surgical methods have improved the outlook for surgery on these dangerous anomalies.

Greenblatt, Robert B., Medical College of Georgia, Augusta, Ga. "Premenstrual Tension Syndrome," GP 11:66-68 (Mar.) 1955.

Accompanying the cyclic occurrence of menstruation is a train of unpleasant symptoms that are frequently distressing enough to warrant medical care. The problem of major menstrual molimina is so common that it should command the attention of every physician in general practice and particularly the physician in industry. Major menstrual molimina is known by many other names, some most descriptive, such as premenstrual tension, premenstrual intoxication, premenstrual syndrome and premenstrual distress.

In private practice, no one single approach will suffice for all patients. Each patient will have to be individually evaluated. If premenstrual edema is the great factor then diuretics such as Neo-Bromth, Diamox or ammonium chloride may be tried. If apprehension, antisocial and behavior problems seem dominant, then a tranquilizing agent such as reserpine may be used. When, as so commonly occurs, many factors appear to be involved in the production of the symptom complex of premenstrual tension, then Morton's regimen of multiple protein feedings with Premens may be used to advantage. Where there are stigmas of endocrine dysfunction such as scanty menses or hypermenorrhea, progesterone may be tried in one case and androgens in the other. Frequently more than one method may be required.

Olansky, Sidney; Cutler, John C.; Price, Eleanor V., U. S. Public Health Service, Chamblee, Georgia. "Treatment of Early Syphilis," A.M.A. Arch. Dermat 71:239-244 (Feb.) 1955.

A report is given of the experience of the Venereal Disease Program of the Public Health Service in evaluation of penicillin G procaine in oil with 2 per cent aluminum monostearate in the treatment of primary and secondary syphilis.

1. As little as 300,000 units of PAM was effective in the treatment of seronegative primary syphilis.

2. The optimum dosage for seropositive primary syphilis appeared to be 2,400,000 units.

3. In secondary syphilis best results were obtained with the highest dosage employed, 9,600,000 units, though not significantly better than 4,800,000 units.

4. No difference in results was observed when PAM was administered in a single session or in divided doses over a period of several days.

Norris, Jack C., 138 Doctors Building, Atlanta, Ga. "Staphylococcus Aureus Hemolyticus and Antibiotics", Med. Times 83:253-255 (Mar.) 1955.

The report deals with Staphylococcus Aureus Hemolyticus cultured from an acute pustular dermatitis on the hand, probably secondary to an allergy. The bacteriology was concerned most with antibiotics. Nine antibiotics were tested for sensitivity on blood agar plates. It was found that Chloromycetin, Ilotycin, Erythrocine and Bacitracin were very effective. In fact the germ was completely inhibited and apparently destroyed by those sub-

stances. Penicillin was of no value at all against this strain of bacteria; other antibiotics such as Streptomycin, Terramycin, Achromycin and Polymixin were mildly inhibitive. Previous reports by other investigators had indicated that Penicillin was the antibiotic of choice in Staphylococcus Aureus Hemolytic infections, but our investigation refuted that claim. It would seem, in treating diseases due to the above organism, that Chloromycetin, Ilotycin or Erythrocine taken internally and applied to the lesion would offer the best chance of cure; furthermore sensitivity tests will usually reveal the correct sensitivity of any infectious germ, thus saving the patient time and expense in treatment.

Fales, Frank W., Ph.D., Emory University Hospital, Emory University, Ga. "Identification of Urinary Sugar", Am. J. Clin. Path. 25:336-339 (Mar.) 1955.

A method for identifying urinary sugars by a fermentation test and simple paper chromatography was presented. The fermentation test was carried out by determining the reducing sugar content, before and after yeast fermentation. The final identification was made by a simple chromatographic procedure. No special reagent or equipment was required and the procedure was readily adaptable to the clinical laboratory.

Boyd, Montague L., and George H. Holsenbeck, 563 Capitol Avenue, S. W., Atlanta, Ga. "A New Type of Tube for Ureteral Intubation", J. Urol. 73:674-676 (April) 1955.

Following some of the plastic operations on the ureteropelvic junction to relieve obstruction, it is desirable to leave in an intubating catheter for from two to six weeks. Where ureterotomy is done for stricture, intubation is also desirable. As a rule, a 12 or more often a 14 F. catheter is used.

While so large a size is desirable for the area of operation, it seems undesirable to have so large a size in the ureter below the operative site.

So we have devised a catheter which is 14 F. in the upper part, and 8 F. in the lower part and has a short taper between the two sizes.

Polyethylene is the material of choice. So far, it has not been ascertained that polyvinyl is suitable although it is so much more pliable than polyethylene, which is stiff.

Greenblatt, Robert B., Medical College of Georgia, Augusta, Ga. "Metabolic and Psychosomatic Disorders in Menopausal Women", Geriatrics 10:165-169 (April) 1955.

Women who enter the stressful period of the middle years with a decline or complete loss of ovarian function frequently need more than sedation or simple psychotherapy to control their symptoms. Though much of the symptomatology may be attributable to psychosomatic disturbances and autonomic nervous imbalance, the attending metabolic disorders must not be overlooked. These metabolic alterations may be managed best by estrogens or, at times, combinations of estrogens and androgens and other hormones. The psychosomatic disturbances may be handled by autonomic depressant drugs, tranquilizing agents, a sympathetic attitude on the part of the physician, and lastly, use of steroid hormones whenever indicated.

Bauer, Heinz; Libero Ajella, Ph.D.; Elizabeth Adams; and Domingo Useda Hernandez, Dept. of Pathology, Emory University School of Medicine, Emory University, Ga. "Cerebral Mucormycosis: Pathogenesis of the Disease", Am. J. Med. 18:822-831 (May) 1955.

Rhizopus oryzae has been isolated and identified as the infectious agent in one of two diabetic patients dying of cerebral mucormycosis.

To our knowledge this rare and fatal complication of diabetes mellitus has never been diagnosed prior to the patient's death.

The clinical and autopsy findings of this fungus disease in our own and previously reported cases are reviewed. The paranasal sinuses are suggested as a possible portal of entry of the infection and problems of pathogenesis are discussed.

From this study emerges a syndrome consisting of uncontrolled diabetes mellitus associated with ophthalmoplegia, signs of meningoencephalitis and, possibly, sinusitis. These characteristic manifestations may permit an antemortem diagnosis of this disorder.

Rheumatic Fever Can Be Prevented!

THOMAS L. ROSS, JR., M.D., Macon, Ga.

FROM 1950 THROUGH 1953 deaths in Georgia from rheumatic fever and rheumatic heart disease averaged 294 per year with a peak number of 324 in 1952. This puts these diseases consistently among the top 10 diseases causing death in our state.

Since it has now been established that rheumatic fever follows infection with Group A streptococcus, an infection which can be prevented, it is now possible to reduce the incidence, morbidity, and mortality rate of this treacherous disease.

Continuous prophylaxis with sulfa drugs or antibiotics will reduce the recurrence rate by 90 per cent; in the era before this knowledge was employed, the recurrence rate was 60-75 per cent.

All children and young adults who have had rheumatic fever, adults who have had an attack within five years, and everyone with rheumatic heart disease should be given the benefit of prophylaxis with antibiotics.

Daily oral doses of the sulfonamides from 0.5 gram to 1.5 gram/day will effectively reduce the incidence of recurrence. It should be realized that these drugs are bacteriostatic in their action rather than bactericidal and will not eliminate the streptococcus from the nasopharynx. Furthermore they may give rise to toxic reactions such as agranulocytosis and exfoliative dermatitis; such complications are rare, but we have had one such reaction in our clinic.

The cost of oral penicillin is slightly higher but this drug is more effective and reactions are less often seen. The recommended dosage is at least 200,000 to 250,000 units once or twice daily.

Many patients and physicians may prefer a monthly injection of benzathine penicillin (Bicillin) in a dosage of 1,200,000 units which is highly effective and more economical. This has its advantages in that there are no breaks in dosage and the physician has better control over the regimen by seeing

the patient monthly. Hypersensitivity reactions are no more frequent or severe than with parenteral use of other forms of penicillin.

Prophylaxis should be begun as soon as the diagnosis of rheumatic fever has been made, and after a course of penicillin sufficient to completely eradicate the streptococcus from the nose and throat. At the present time it is felt that prophylaxis should be continued for many years but certainly for five years, at which time present divergent opinions will have crystallized.

The prevention of the initial attack of rheumatic fever depends on prompt and adequate treatment of any streptococcal infection, particularly a "strep sore throat". Treatment is only adequate when the organisms are completely eradicated.

A simple cold with coryza, headache, hoarseness, and accompanying sore throat—"nasopharyngitis, catarrhal, acute," the old Army term—is rarely due to the streptococcus. The explosive onset of severe sore throat, high fever, beefy redness of the throat, and tenderness from cervical adenitis, with high leucocytosis suggest the diagnosis; in such cases, and in doubtful cases, a throat culture is highly recommended.

Adequate treatment of acute streptococcal nasopharyngitis may be obtained: (1) by a single injection of 1,200,000 units of benzathine penicillin; (2) by 600,000 units of procaine penicillin in oil with two per cent monostearate every other day for three to four doses; (3) by a daily dose of 300,000 units of aqueous procaine penicillin for 10 days; and (4) by at least 500,000 units of penicillin by mouth daily for 10 days. The throat should then be recultured for the presence of streptococci.

With these measures we can STOP RHEUMATIC FEVER. This disease may well be the next major scourge of childhood to yield to advancing medical knowledge.

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.



BOOKS RECEIVED

Eichenwald, Heinz F., M.D., C. D. C., *Viral Hepatitis—Clinical, Laboratory, and Public Health Aspects*, U. S. Department of Health, Education, and Welfare, Washington, D. C., 1955, 59 pp., 55c.

Silver, Henry K., M.D.; C. Henry Kempe, M.D.; and Henry B. Bruyn, M.D.; *Handbook of Pediatrics*, Lange Medical Publications, Los Altos, California, 1955, 448 pp., \$3.00.

Wolstenholme, G. E. W., O.B.E., M.A., A.B.L.S.; and Margaret P. Cameron, M.A., A.B.L.S. (Editors); *The Human Adrenal Cortex, Ciba Foundation Colloquia on Endocrinology, Vol. VIII*, Little, Brown and Company, Boston, 1955, 665 pp., \$10.00.

Abramson, Harold A., M.D. (Editor), *Problems of Consciousness, Transactions of the 5th Conference*, Josiah Macy, Jr. Foundation, New York, 1955, 180 pp., \$3.50.

Harvey, A. McGee, M. D., and James Bordley, III, M.D., *Differential Diagnosis, The Interpretation of Clinical Evidence*, W. B. Saunders Company, Philadelphia, 1955, 665 pp., \$11.00.

Surgical Forum, Proceedings of the Forum Sessions, 40th Clinical Congress of the American College of Surgeons, Atlantic City, N. J., November 1954; W. B. Saunders Company, Philadelphia, 1955, 851 pp., \$10.00.

Boyd, William, M. D., *Pathology for the Surgeon*, Seventh Edition, W. B. Saunders Company, Philadelphia, 1955, 737 pp. 547 ill., \$12.00.

Cecil, Russell L., M.D., Sc.D., and Robert F. Loeb, M.D., Sc.D., D. Hon. Causa, LL.D. (Editors), *A Textbook of Medicine*, Ninth Edition, W. B. Saunders Company, Philadelphia, 1955, 1786 pp., \$15.00.

Collected Papers of the Mayo Clinic and the Mayo Foundation, Vol. XLVI—1954, W. B. Saunders Company, Philadelphia, 1955, 843 pp., 189 figures, \$12.50.

Masserman, Jules H., M.D., *The Practice of Dynamic Psychiatry*, W. B. Saunders Company, Philadelphia, 1955, 790 pp., \$12.00.

Wolstenholme, G. E. W., O.B.E., M.A., M.B., B.Ch.; and Margaret P. Cameron, M.A., A.B.L.S. (Editors), *Ageing—General Aspects, Ciba Foundation Colloquia on Ageing, Vol. I*, Little Brown and Company, Boston, 1955, 255 pp., \$6.75.

REVIEWS

Samuel H. Golter, **THE CITY OF HOPE.**

The City of Hope is a revealing dramatic story told in numerous chapters of this book. It is a challenge to those people who view any undertaking as insurmountable. From a small beginning of two tents, as a nucleus for the case of indigent people who have tuberculosis, it has grown to a complex group of facilities for treatment of this disease.

Samuel H. Golter, the author, accepted a further challenge in the interest of those suffering from cancer. Only those without funds are accepted, and the support is derived from people in all walks of life, every creed, race, and religion. The medical staff is full time, and evidently well trained in the special fields of all types of treatment and research in catastrophic illness, such as tuberculosis, cancer, leukemia, and heart trouble. The whole story is one of dedication, courage, perseverance, and hope. Spiritual welfare is just as much a part as the physical treatment.

The author closes this varied, courageous, and dramatic story with the thought that the reward to all those concerned is an enduring legacy to posterity. It is the irony of fate that the author developed cancer while striving to help others.

Carl C. Aven, M.D.

Reifenstein, Edward C., Jr., **METABOLIC INTER-RELATIONS WITH SPECIAL REFERENCE TO CALCIUM (Fifth Conference)**, Josiah Macy, Jr. Foundation, New York, 1954, 369 pages, 127 illustrations, \$5.00.

This book is a series of transactions of a scientific meeting attended by specialists in the field of Calcium Metabolism. All of the recent concepts of the structure and metabolism of bone are presented.

As is true of most symposia, conflicts in current concepts are reviewed, and the most recent experimental evidence in the field is mobilized to fit the individual experimenter's theoretical approach. As a result, areas of controversy about gaps in our knowledge are presented in the text, and the reader (unless an expert himself) is apt to be more confused than enlightened.

This book will be of interest as a reference in the medical school or hospital library and for a few physicians who are interested in the theoretical aspects of the metabolism of calcium and phosphorus. The bibliographies accompanying the articles present current references. There is no index, which limits the usefulness of this type of symposium.

Walter L. Bloom, M.D.

Statement on Retroental Fibroplasia With Reference to Oxygen Administration*

(The following report is reprinted, with permission, from *The Maryland State Medical Journal*, Vol. 4, No. 2, February 1955, at the request and with the approval of the Committee on Maternal and Infant Welfare of the Medical Association of Georgia. Ed.)

The evidence continues to incriminate excessive oxygen administered over a prolonged period as the major cause of retroental fibroplasia in premature infants. A review of recently published studies of this subject, abstracts of which are included at the end of this statement, has convinced the Committee that immediate action is required.

It is strongly urged that the following policies with respect to oxygen administration be adopted at once by all hospitals caring for newborn infants:

1. All babies under 1500 grams shall continue to receive routine oxygen for 24 hours, the concentration of which shall be kept between 30 and 40 per cent as checked by measurement with an oxygen analyzer (1) every eight hours. These infants shall be removed as soon thereafter as qualified nursing and medical estimates of the infant's status permits.
2. Oxygen shall be prescribed for individual infants by the physician on the basis of clinical symptoms, particularly cyanosis.
3. Under no circumstances shall oxygen be administered in concentrations exceeding 40 per cent, except briefly for emergencies.
4. The actual concentration of oxygen during administration shall be checked by measurement with oxygen analyzer (1) at least every eight hours.
5. The continuous administration of oxygen for periods in excess of three days should be prescribed only in cases of real need. The indications for continued oxygen therapy should be re-evaluated by the physician daily. Where oxygen is administered for periods longer than three days, extreme caution should be exercised to measure the oxygen concentration to see that it does not exceed 40 per cent.

*Adopted at Committee meeting November 18, 1954.

1. Until such time as an oxygen analyzer can be purchased, it is recommended that a flow of not more than five liters per minute be permitted in the Gordon-Armstrong type incubator and from one-half to one liter per minute in the Isolette. Complete instructions for the maintenance of oxygen concentration in the Isolette have recently been mailed by the manufacturer to all hospitals owning these incubators. These instructions should be kept in the nursery and followed closely. If you do not have a copy, write immediately to Air-Shields, Inc., Hatboro, Pa. The important recommendation on Isolettes concerns those bearing serial numbers below 3566. In these incubators the small "float" in the air oxygen intake assembly should be removed.

To remove float from air-oxygen intake assembly, unscrew oxygen intake nipple with a $\frac{3}{4}$ inch wrench. Remove float and replace the nipple. If the float does not drop out easily, it can be dislodged with the eraser end of a pencil or by tapping the assembly block.

With respect to oxygen analyzers the Committee finds that most of the Maryland experience has been with the Beckman instrument manufactured by Arnold & Beckman, Inc., 1020 Mission St., South Pasadena, California. It is accurate and exceedingly simple to use. The cost is approximately \$210.00.

Although the relationship between high concentration of oxygen and retroental fibroplasia has been described in various papers in medical journals, there is an evident lag in application of this knowledge in the hospital nursery care of premature infants. The National Society for the Prevention of Blindness recently questioned a large number of well-known hospitals throughout the country and found that a considerable number of them had not yet taken definitive action to adjust their oxygen administration procedures to minimize the threat of visual damage.

A recent check reveals that the Maryland School for the Blind now has registered approximately 160 blind children of preschool age who are awaiting admission. Of these, 130 (80 per cent) are due to retroental fibroplasia. This is a matter of deep concern to the Committee, and we believe it constitutes an emergency in preventive medicine.

The following abstracts with references compiled by the National Society for the Prevention of Blindness should be studied with care---together with the papers themselves---by all physicians, chiefs of newborn nursery service, hospital administrations, and others responsible for the policies of newborn nurseries.

*Committee on Maternal and Child Welfare
Medical and Chirurgical Faculty of Maryland*

Selected References Concerning Association of High Oxygen Administration With Occurrence of Retroental Fibroplasia

Crosse and Evans (1) of Birmingham, England, reported occurrence of six cases of retroental fibroplasia during period when there was much use of oxygen; no cases after oxygen administration was curtailed. K. Campbell (2) reported a similar observation in Melbourne, Australia.

Patz (3) reported that seven cases of advanced irreversible RLF occurred among 28 infants receiving high oxygen—65 to 70 per cent, contrasted with no such cases among 31 infants of same weight group during same period who received low concentrations of oxygen.

Ashton et al (4) found that retinal blood vessels of full-term kittens were in same stage of development as those of premature human infants, and found that high oxygen concentrations (60 to 80 per cent) obliterated developing blood vessels in the kitten, following which retinal hemorrhages sometimes occurred, and retinal detachment.

Patz et al (5) produced ocular lesions closely resembling RLF in newborn kittens, puppies, rats, and mice by placing them in 70 to 80 per cent oxygen concentrations: litter mates at room oxygen did not develop such lesions.

Gordon et al (6) reported 10 per cent of 80 infants receiving unscrutinized moderate oxygen developed RLF membranes; later, 35 per cent of 20 infants on unscrutinized high oxygen had such membranes; during a transitional period, oxygen administration gradually was reduced, and 21 per cent of 14 infants had RLF membranes; during the subsequent period, with oxygen concentrations kept below 40 per cent, only two per cent of 97 infants developed RLF membranes. Survival rates were not adversely affected by restriction of oxygen.

Locke (7) reported that 60 of 160 premature babies

who received prolonged oxygen therapy at Lincoln and Presbyterian Hospitals developed acute lesions of RLF; in Montreal, six of 43 prematures on unrestricted oxygen developed RLF; later only minimal oxygen was given in Montreal hospitals with which Locke was connected, and only two cases occurred among 124 infants.

Lanman et al (8) reported on a controlled study at Bellevue Hospital where 36 infants received high oxygen (averaging 69 per cent) and 28 low oxygen (less than 40 per cent and then only for cyanosis). Eight of the infants in high oxygen developed cicatricial RLF; none of those in low oxygen developed the cicatricial stage.

Kinsey (9) gave a preliminary report on a cooperative study among 18 hospitals with randomized controls. All premature infants weighed less than 1500 grams and all were followed ophthalmologically for at least three months. Of 53 infants who received prolonged, high oxygen, 25 per cent developed cicatricial RLF; of 245 infants who were in the curtailed group, only six per cent showed cicatricial RLF. Most of the risk of developing RLF seemed to occur by exposure to high oxygen during the first week of life. There was no significant difference in mortality rates of the two groups of infants. A. B. Reese (9), chairman of the RLF panel, recommended that routine administration of oxygen to premature babies be discontinued, that it be given only if there be cyanosis or respiratory disease, that in such cases the concentration inside the incubator be kept below 40 per cent as measured by an oxygen analyzer, and that oxygen therapy be discontinued as soon as respiratory distress is relieved.

Gordon (10) has very recently summarized all the evidence to date in an editorial in *Pediatrics* and recommends a sensible and balanced view on action which should be taken.

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9. Kinsey, V. E., and Reese, A. B., et al. Symposium on Retrolental Fibroplasia. Unpublished, annual meeting of Amer. Acad. of Ophthalm. and Otolaryn., New York, N. Y. Sept. 22, 1954.
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Seventh District PR Conference

June 30, 1955, Rome, Ga.

THE MEDICAL ASSOCIATION OF GEORGIA Public Relations Committee held the Seventh District Presidents' and Secretaries' Conference at 6:00 p.m., Thursday, June 30, 1955 in the Greystone Hotel, Rome, Georgia. Invited to this conference of county society officers were some nine county medical society presidents and secretaries. Attending the meeting were L. L. Alexander, President, and E. M. Townsend, Secretary of Walker-Catoosa-Dade; Willard Carson, President, Lloyd C. Yeargin, Secretary, and Albert M. Boozer, Public Relations Chairman of Whitfield County Medical Society; C. K. Richards, President of Gordon County Medical Society; E. S. Brannon, President of Floyd County Medical Society; A. L. Horton, Secretary of Bartow County Medical Society; George Cauble, President of Cobb County Medical Society; J. W. Watts, President, and D. S. Reese, Secretary of Carroll-Douglas-Harralson County Medical Society; R. D. Walters, Past-President, and C. B. Elliott, Secretary of the Seventh District Medical Society; and D. Lloyd Wood, Councillor from the Seventh District to the Medical Association of Georgia.

Also in attendance were Chris J. McLoughlin, Atlanta, Chairman of the MAG Public Relations Committee; William Harbin, Rome, Past-President of the MAG; and the Messrs. John F. Kiser and Milton D. Krueger of the headquarters office.

The meeting was called to order immediately after a dinner held in the Greystone Hotel. Dr. McLoughlin introduced William Harbin, who welcomed all the officers of the county medical societies in the Seventh District. As local host to the conference, E. S. Brannon, President of Floyd County Medical Society, greeted all members in attendance.

Mr. John F. Kiser, MAG Assistant Executive Secretary, then spoke on the subject, "Role of the County Medical Societies." Mr. Kiser's remarks concerned the importance and the activity of the eighty county medical societies making up the Medical Association of Georgia.

Mr. Milton D. Krueger, Executive Secretary of the MAG, spoke on the topic, "Your Society and the Medical Association of Georgia." Mr. Krueger reported on the progress to date of the 25 committees of the Association.

"Medicine in the Public Eye" was the title of Dr. McLoughlin's presentation; he highlighted nine or 10 projects that make for a stronger medical society and better relations in each community between the profession and the public. Dr. McLoughlin then called for general discussion, and a "shirt sleeve" session concerning county medical society problems lasted about one and a half hours. The meeting was adjourned after the general discussion.

SECOND CALL FOR SCIENTIFIC PAPERS

106th Annual Session

See inside back cover

Physicians Recently Licensed to Practice in Georgia

According to R. C. Coleman, Joint Secretary of the State Examining Boards, the following appli-

cants were licensed by examination to practice medicine in Georgia July 5, 1955:

Fred Larimore Allman, Jr., Atlanta, Ga.
 Patrick Lloyd Anders, New York, N. Y.
 John William Andrews, Atlanta, Ga.
 William Wallace Andrews, III, Nashville, Tenn.
 Hubert Franklin Anthony, Jr., Royston, Ga.
 William Thomas Atrial, Cornelia, Ga.
 Bill Martin Bailey, Harlem, Ga.
 Joseph Peyton Bailey, Jr., Augusta, Ga.
 Melvin Scott Bard, Jr., Nashville, Tenn.
 Pat Smith Barrow, Atlanta, Ga.
 John Hagan Baskin, Jr., Decatur, Ga.
 Percy Dean Baugh, Nashville, Tenn.
 Wilbur Edwin Baugh, Milledgeville, Ga.
 James Harvey Beall, Carrollton, Ga.
 Melvin Berlin, Savannah, Ga.
 Lowell James Black, Jr., Montgomery, Ala.
 Charles Neal Bland, Washington, D. C.
 James Edward Bleckley, Clayton, Ga.
 Edwyn Taylor Bowen, Jr., Atlanta, Ga.
 William Joseph Bradley, II, Atlanta, Ga.
 Montague Delano Brantley, Sumter, S. C.
 William McKinley Brown, Jr., Sacramento, Calif.
 Edward Garey Bryant, Jr., Savannah, Ga.
 Michael Sterling Buckner, Baltimore, Md.
 James Wareham Burnham, Jr., Macon, Ga.
 Emil Eddy Burns, Atlanta, Ga.
 Carroll Daniel Cabaniss, Columbus, Ga.
 Kenneth Paul Carlson, Decatur, Ga.
 William House Chambless, Decatur, Ga.
 Lamar Pitcher Collie, Jr., Augusta, Ga.
 Kenneth Conoley, Atlanta, Ga.
 William Calhoun Cooper, Jr., Birmingham, Ala.
 Edwin Duff Crane, III, Atlanta, Ga.
 James Lee Cross, Atlanta, Ga.
 Morris Norton Dalton, Summerville, Ga.
 Lloyd Cleveland Davis, Ellijay, Ga.
 Robert Earl Delgado, Atlanta, Ga.
 Ray Eugene Dellinger, Decatur, Ga.
 Edzell Phenon Dickerson, Orlando, Fla.
 James Crawford Dudley, Jr., Americus, Ga.
 James Boyd Dunaway, Atlanta, Ga.
 Byron Harrison Dunn, Zebulon, Ga.
 Henry Turner Edmondson, Pineview, Ga.
 Ian Keith Edwards, Atlanta, Ga.
 Raymond Daniel Evans, Gainesville, Ga.
 McKinley Michael Exum, Memphis, Tenn.
 William Henry Fleming, II, Augusta, Ga.
 Waldo Emerson Floyd, Jr., Statesboro, Ga.
 Harry Robert Foster, Jr., Summerville, Ga.
 Archie Theopolis Frazier, Nashville, Tenn.
 Lawrence Lee Freeman, Atlanta, Ga.
 Malcolm Godsey Freeman, Emory University, Ga.
 John George Fries, Savannah, Ga.
 Carl Fromhagen, Jr., Decatur, Ga.
 David Ramsey Gair, Miami, Fla.
 Paul Bernardo Garcia, Griffin, Ga.
 Anne Hendrick Gaston, Decatur, Ga.
 Joseph Harper Gaston, Decatur, Ga.
 Albert James Geiger, Jr., Atlanta, Ga.
 Thomas Richard Giblin, Decatur, Ga.
 Clyde Ellis Gibson, Decatur, Ga.
 Thomas Ashford Gibson, Atlanta, Ga.
 Frank Edward Gill, Jacksonville, Fla.
 Walter Carl Gordon, II, Albany, Ga.
 Martha Cole Gordy, Columbus, Ga.
 Stanley Leo Gould, College Park, Ga.
 George Davd Gowder, Jr., Gainesville, Ga.
 Edward Wendell Graham, Nashville, Tenn.
 Solomon Sylvester Green, Jr., Nashville, Tenn.
 James Lee Guest, Jr., Atlanta, Ga.
 Victor Reid Gullatt, Cochran, Ga.
 William Schweigert Hagler, Augusta, Ga.
 Charles Clinton Hall, Orlando, Fla.
 Jack Billie Hanks, Atlanta, Ga.
 John Robert Harrison, Macon, Ga.
 Hezekiah K. Heath, Jr., Homerville, Ga.
 Joseph Anthony Heffernan, Jr., Savannah, Ga.
 Sonnie Wellington Hereford, III, Huntsville, Ala.
 William Ray Hodges, Brinson, Ga.
 Robert Wallace Hubbell, Atlanta, Ga.
 Prentis Baker Huff, Atlanta, Ga.
 Walter Jones Hughes, Jr., Nashville, Tenn.
 Jess Lindsey Hunt, College Park, Ga.
 Charles Garden Johnson, Atlanta, Ga.
 Janet King Johnson, Dahlonega, Ga.
 Martin Luther Johnson, Jr., Bowdon, Ga.
 Ransom Lanier Jones, Atlanta, Ga.
 George Mitchell Katibah, Jacksonville, Fla.
 Frank DeWald Kilgo, Atlanta, Ga.
 William Enloe Kilgore, Ocala, Fla.
 James Myron Collins Kitaif, Covington, Ga.
 Houston W. Kitchin, Decatur, Ga.
 James Spullock Lambert, Fairburn, Ga.
 Constantine Peter Lampros, Rome, Ga.
 Paul Alan Lavietes, Atlanta, Ga.
 Quentin Tally Lawson, Hahira, Ga.
 Robert Nelson Lee, Inkster, Mich.
 John George Leonardy, Jr., Coral Gables, Fla.

Louis Peter Leopold, Savannah, Ga.
 Esley Earle Lewis, Shady Dale, Ga.
 Charles Howard Little, Jasper, Ga.
 James Lawton Lodge, Jr., Whigham, Ga.
 Paul Hargrave Logan, Petersburg, Va.
 William Henry Lucas, Jr., Cedartown, Ga.
 Luther Wade McCaskill, Holcomb, Miss.
 Carl Leon McGahee, Jr., Emory University, Ga.
 Abraham McIntosh, Jr., Townsend, Ga.
 Charles Byron McIntosh, Jr., Jacksonville, Fla.
 Irwin Chester McLendon, Hazlehurst, Ga.
 Anson Joel Mellion, Jacksonville, Fla.
 Harvey Ernest Merlin, Emory University, Ga.
 Betty Ann Hogan Metts, Dudley, Ga.
 James Clayton Metts, Jr., Savannah, Ga.
 Milton Green Middleton, Colquitt, Ga.
 Joe Hardy Miller, Jr., Cleveland, Ga.
 Byron Donald Minor, Atlanta, Ga.
 John Lewis Mitchell, Jacksonville, Fla.
 Thomas Albert Montgomery, Athens, Ga.
 Sarah Agatha Moody, Baxley, Ga.
 Clifton Malvin Moore, Norfolk, Va.
 Louis Stone Moore, Thomasville, Ga.
 Raymond Edmond Moore, Warner Robins, Ga.
 Jim Morris, Surrency, Ga.
 Marvous Eulous Mostellar, LaGrange, Ga.
 James Robert Neill, Emory University, Ga.
 Harold Stanley Nelson, Decatur, Ga.
 Emory O'Neal Newton, Bartow, Fla.
 Joseph Jefferson Nixon, III, Augusta, Ga.
 William Draper North, Jr., Newnan, Ga.
 Richard LaMar Nutt, Griffin, Ga.
 William John O'Shaughnessey, Jr., Macon, Ga.
 Joseph Lawrence Owens, Jr., Atlanta, Ga.
 William Joseph Parker, Montclair, N. J.
 George Robert Parkerson, Jr., Atlanta, Ga.
 Ray Lowell Peacock, Jr., Augusta, Ga.
 Huey Lawrence Pearson, Glenwood, Ga.
 Edward Pedrero, Jr., Tampa, Fla.
 James Morris Perkins, Decatur, Ga.
 Wesley Glenn Petty, Atlanta, Ga.
 Raymond Olee Pierce, Jr., Monroe, La.
 Benjamin Leonard Pike, Savannah, Ga.
 Jesse J. Pone, Jr., Trenton, N. J.
 James Porter, Jr., Decatur, Ga.
 Ambrose Madison Price, Chicago, Ill.
 Ernest Evers Pund, Jr., Augusta, Ga.
 Keith Axson Quarterman, Jr., Atlanta, Ga.
 Clarence Weaver Rawson, Jr., Augusta, Ga.
 Uthman Ray, Jr., Baltimore, Md.
 William Bradley Read, Nashville, Tenn.
 Edward Wilson Reed, Birmingham, Ala.
 Joseph Lane Reeves, Jr., Savannah, Ga.
 Walter Joseph Reis, Decatur, Ga.
 Howard Dale Richardson, Atlanta, Ga.
 Donald Roe Rooney, Atlanta, Ga.
 Carl Sanford Ross, Williamsburg, Va.
 Roger Ronald Rowell, Vidalia, Ga.
 Ernst Murphy Ruder, Clearwater, Fla.
 Herbert Franklin Ryan, Nashville, Tenn.
 Carl Benjamin Schleifer, Palmetto, Fla.
 Harold Schulman, North Miami, Fla.
 Frank Conrad Schwalbe, Jr., Jacksonville, Fla.
 James Hugh Segars, LaGrange, Ga.
 George Purd Sessions, Dawson, Ga.
 James Zachry Shanks, Atlanta, Ga.
 William Albert Sibbett, Jr., Atlanta, Ga.
 Melvin Ross Simson, Norfolk, Va.
 Marvin Benton Slocumb, Atlanta, Ga.
 Ernest Caldwell Smith, Jr., College Park, Ga.
 Lorraine Bruce Smith, Richmond, Va.
 Warren Young Smith, Montgomery, Ala.
 Lee Mannen Stapp, Decatur, Ga.
 Albert Lawrence Stone, Atlanta, Ga.
 Harry Harlan Stone, Atlanta, Ga.
 William Greene Sutlive, Savannah, Ga.
 Thomas Gordon Taylor, Augusta, Ga.
 Ruth McMinn Thomas, Augusta, Ga.
 Jasper Fritz Thompson, Atlanta, Ga.
 William Robert Thompson, Fairmount, Ga.
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 John Jacob Westermann, Jr., Sea Island, Ga.
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 Jack Wallace Whitworth, Greenville, Ga.
 Edward Herbert Williams, Jr., Atlanta, Ga.
 Robert Earl Williford, Fayetteville, N. C.
 Leonard Edgar Witcher, Danville, Va.
 Morgan Dozier Wynne, Jr., Griffin, Ga.

doctor placement page



NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

AVAILABLE PHYSICIANS

Anthony, James E., Jr., M.D., Presbyterian Hospital, 1753 West Congress St., Chicago 12, Illinois—Age 32; married; Methodist; graduate University of Maryland, 1947; residency Jefferson Hospital, Roanoke, Va.; Emory University Hospital, Atlanta; Presbyterian Hospital, Chicago, Ill.; specialty surgery; available June 1957.

Bell, John Arthur, M.D., 651 East 14th Street, New York 9, N. Y.; Married; Protestant; graduate Cornell University Medical College, 1949; residency II (Cornell) Medical Division, Bellevue Hospital, N. Y. C.; available July 1, 1955.

Calkins, Robert S., M.D., 8983 Mission Boulevard, Riverside, Calif. — Age 36; married; Presbyterian; graduate Oklahoma University, 1947; residency Presbyterian Hospital, Philadelphia, Pa.; specialty O. B. Gyn; available now.

Campbell, Roy E., M.D., Valley Forge Army Hospital, Phoenixville, Pennsylvania—Age 36; married; Baptist; graduate Emory Medical School, 1943; residency Grady Memorial Hospital, Atlanta; at present in Army will leave in July, 1955; has a Georgia and Florida license; available July 10, 1955.

Compton, William S., M.D., 3256 East Huntington Drive, Decatur, Ga.—Age 29; married; Presbyterian; graduate Medical College of Georgia; residency one year Crawford W. Long, Atlanta, Ga.; available August 1, 1955.

Mason, Roscoe E., M.D., Surgical Service U. S. Army Hospital, Fort Bragg, North Carolina—Age 32; married; Methodist, graduate Harvard Medical School, 1948; residency Boston City Hospital 13 months remainder including chief residency at Tripler General Hospital (U. S. Army) Oahu, T. H.; expect to be discharged August 1, 1955; available 1-15 August, 1955.

Melcher, Truman O., M.D., ENT Clinic, John Sealy Hospital, Galveston, Texas—Age 41; married; Protestant; graduate University of Texas School of Medicine, 1942; residency John Sealy Hospital; member AMA; specialty otolaryngology and endoscopy; available September 1, 1955.

Roth, Robert Earl, M.D., USVA Hospital, Nashville 5, Tennessee—Age 30; married; Protestant; graduate University of Illinois, 1949; residency VA Hospital, Nashville, Tennessee; specialty radiology; available August 1955.

AVAILABLE LOCATIONS

Arlington, Georgia (Calhoun County)—Population 1,382. In need of doctor-surgeon for practice in new excellently equipped 16-bed hospital, located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia.

Atlanta, Georgia (Fulton County)—Needed immediately, young man doing general medicine interested in association with established X-Ray and clinical laboratories. Contact: Drs. Landham & Klugh, 736 Piedmont Avenue, N.E., Atlanta, Georgia.

Broxton, Georgia (Coffee County)—Population 3,500—Doctors clinic available; also home available; 60 room county hospital at Douglas; seven room doctors building; no physician in area; physician will have more work than he can do. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia.

Dillard, Georgia (Rabun County)—Population 2,500. Doctor's office to be furnished rent free for one year; would rent five or six room house, fully equipped kitchen, county hospital at Clayton; drug store and pharmacist; good schools; doctor would be welcome right now; late doctor had an excellent practice; other benefits considered in a short time; active church groups and community club that would be happy to assist doctor. Contact: Mrs. L. Neville, Dillard, Georgia.

Edison, Georgia (Calhoun County)—Population 1,245. Two physicians in area;

Hill-Burton Hospital (1 mi.); one clinic local with 10 beds, x-ray, lab equipment, operating room with instruments; rental \$75.00 (maximum \$100.00) per month; two excellent drug stores; housing available for rent at \$30-\$40; good elementary and high schools; five churches; great need for a physician in this community. Contact: Dr. J. S. Beard, Edison, Georgia.

Hampton, Georgia (Henry County)—Population 1,000—No doctor in Hampton, nearest 10 miles away; hospital in Griffin; office space, housing available; contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia.

Jeffersonville, Georgia (Twiggs County)—One physician in area doing limited practice; hospital facilities nearby in Macon; office space available with small rental or purchase; one drug store with registered pharmacist; house made available immediately; 69 lakes stocked with bass brim or trout; 150,000 acres woodland makes Twiggs County good hunting ground for small game; definite need for physician. Contact: Mr. H. C. Swearingen, Jeffersonville, Georgia.

Smithville, Georgia (Lee County)—Population 700—No physician in area; home in Leesburg, office downtown rent free; completely equipped office of two rooms and connecting lavatory with outlets for sterilizers, etc., attached. All Contact: Mr. E. H. Conner, Unadilla, Georgia.

Unadilla, Georgia (Dooly County)—Population 1,200—Dooly County Hospital owned and operated by the people of the county; office space available or will build small clinic and let doctor rent or buy. Housing will be provided rent reasonable or can get house built to suit. They guarantee a good doctor will do well; one physician in area, age 75.

Woodbine, Georgia (Camden County)—Population 1,000. Small, fully equipped office and clinic available; ample office space, delivery room, laboratory (inc. x-ray), nursery, wards, private rooms; five room wooden dwelling adjoins hospital available at \$35.00 mo.; one other doctor in Woodbine, doctor is needed now. Contact: Dr. S. C. Atkinson, Waverley, Ga.

please notify . . .

Medical Association of Georgia
875 West Peachtree Street, N. W.
Atlanta, Georgia

. . . when a location has been filled

ANNOUNCEMENTS

American Institute of Dental Medicine—Desert Inn, Palm Springs, Cal., October 23 to 27, 1955. Faculty will consist of Maury Massler, D.D.S., M.S., Chicago; Valy Menkin, M.D., Philadelphia; Hans Selye, M.D., Montreal; Reidar F. Sognnaes, D.M.D., Ph.D., Boston; and Wendell L. Wylei, D.D.S., San Francisco. Applications and full information may be secured from the Executive Secretary, Miss Marion G. Lewis, 2240 Channing Way, Berkeley 4, Cal.

Annual Convention of the National Society for Crippled Children and Adults—Palmer House, Chicago, November 28-30, 1955. Convention sessions will include speeches, institutes, seminars, workshops, round table discussions, and demonstrations by experts in the rehabilitation field. For information write to the National Society for Crippled Children and Adults, 11 South LaSalle Street, Chicago 3, Illinois.

American Dermatological Association, Inc. Annual Prize Essay Contest—Cash prizes (4) will be awarded for the best essays submitted as original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. Manuscripts (in triplicate) must be submitted not later than November 15, 1955. Further information may be obtained by writing to the Secretary of the American Dermatological Association.

Gulf Coast Clinical Society Annual Meeting—Pensacola, Fla., October 27 and 28, 1955. For further information write to Dr. Barkley Beidleman, Secretary-Treasurer, Gulf Coast Clinical Society, 1750 North Palafox Street, Pensacola, Fla.

Academy of Psychosomatic Medicine Second Annual Meeting—Hotel Plaza, New York City, October 6-8, 1955. General subject is "The Psychosomatic Aspects of Drug Administration." Those who wish to present papers at this meeting, are invited to communicate with the program chairman, Dr. Ethan Allan Brown, 75 Bay State Road, Boston 15, Mass. from whom applications for Fellowship and copies of the Constitution may also be obtained.

American Congress of Physical Medicine and Rehabilitation 33rd Annual Session—Hotel Statler, Detroit, August 28-September 2, 1955. Full information may be obtained by writing to the Executive Secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

The Georgia Diabetes Association was organized May 2, 1955, during the Annual Session of the Medical Association of Georgia. This organization is designed to stimulate interest in diabetes among the physicians of this state.

Plans are being made to organize subsidiary lay groups. Through these agencies a program of public education will be fostered with particular emphasis on education of the diabetic in the care of his disease. Such a group has been active in Atlanta for some time.

The Georgia Diabetes Association will guide these lay groups, furnish speakers to medical societies on request, and offer all possible help in the diagnosis and treatment of diabetes. Plans for an active research program are being considered.

At the first meeting officers were elected. Christopher McLoughlin, Atlanta, is president; George R. Dillinger, Thomasville, vice-president, and Alex T. Murphey, Augusta, secretary-treasurer.

The next meeting will be held in Atlanta in September. At that time a constitution will be established and plans made for obtaining a suitable visiting speaker for the next MAG Annual Session. Problems of organizing local lay groups will be discussed. Guy H. Adams, C. R. Arp, and E. Van Buren of Atlanta are in charge of arrangements for this meeting.

All physicians interested in diabetes are cordially invited to join. Dues are four dollars (\$4.00) per year. Checks should be made out to The Georgia Diabetes Association and mailed to:

Dr. Alex T. Murphey, Secretary-Treasurer
Georgia Diabetes Association
1132 Druid Park Ave.
Augusta, Georgia

Post Graduate Course in Pediatric Allergy—New York Medical College, Flower and Fifth Avenue Hospitals, each Wednesday, November 2, 1955, through May 31, 1956. Applicants must be certified in pediatrics or have the requirements for certification. Enrollment limited, fee \$300.00. Research fellowship in Pediatric Allergy available. Apply: Office of the Dean, New York Medical College, Fifth Avenue at 106th Street, New York 29, N. Y.

Directory—"Cancer Services and Facilities in the United States, 1954"—Compiled by the National Cancer Institute, can be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for 45 cents a copy.

Tennessee Valley Medical Assembly—Read House, Chattanooga, Tenn., October 3 and 4, 1955. This meeting is sponsored by the Chattanooga and Hamilton County Medical Society and will have approximately 16 nationally known guest speakers. For reservations write to: Chattanooga, Inc., 819 Broad Street, Chattanooga, Tenn.

Eight Week Comprehensive Course in Industrial Medicine—beginning September 26, 1955, Post-Graduate Medical School of New York University-Bellevue Medical Center, New York City. Among the subjects offered are: organization, administration and economics of an industrial medical department; the practice of preventive and constructive medicine in industry; the clinical aspects of occupational diseases; industrial injuries and the elements of safety programs; and toxicology and industrial hygiene for the physician. Applications should be sent to the Dean, NYU Post-Graduate Medical School, New York 16, N. Y. Tuition \$250.00.

American Medical Writers' Association 12th Annual Meeting and Workshop—Hotel Jefferson, St. Louis, Mo., September 30 and October 1, 1955. All physicians and collegiate graduates interested in medical writing, journalism, or publishing are cordially invited. No registration fee for the meeting, but non-members will

pay a \$5.00 registration fee for the workshop, which will be conducted by Richard Hewitt, M.D. For further information write Harold Swanberg, M.D., Secretary, 209-224 W. C. U. Building, Quincy, Ill.

Fellowships for Basic Research in Arthritis—The Arthritis and Rheumatism Foundation is offering the following research fellowships: (1) predoctoral fellowships ranging from \$1,500 to \$3,000 per year, (2) postdoctoral fellowships ranging from \$4,000 to \$6,000 per year, and (3) senior fellowships for more experienced investigators which will carry an award of \$6,000 to \$7,500 per year. Deadline for applications is October 15, 1955. For information and application forms address the Medical Director, The Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, N. Y.

Postgraduate Assembly of the Endocrine Society 7th Annual Meeting—Indiana University Medical Center, 1100 West Michigan St., Indianapolis, September 26-October 1, 1955. "Endocrinology and Metabolism" is the subject for the sessions at which 21 leading clinicians and investigators will be heard. For information, write: Postgraduate Office, Indiana University School of Medicine, 1100 West Michigan, Indianapolis 7, Indiana.

Georgia State Obstetrical and Gynecological Society—Macon, Ga., October 21, 1955. Speakers will be announced later. For further information write to J. Lon King, Jr., M.D., 817 Persons Bldg., Macon, Georgia.

Mississippi Valley Medical Society 20th Annual Meeting—Hotel Jefferson, St. Louis, Mo., September 28-30, 1955. All members of the AMA are cordially invited to attend the meeting and are urged to become active society members. The MVMS annual meetings have been accredited by the American Academy of General Practice for informal post-graduate attendance credit. For further information write to Harold Swanberg, M.D., 209-224 W. C. U. Bldg., Quincy, Illinois.

Nine Refresher Courses Covering the Serology of Syphilis, Management and Control of Syphilis Serology by the Regional Laboratory, and Tests for Syphilis Using the Treponema Pallidum—Venereal Disease Research Laboratory, Chamblee, Ga., September 1955-May 1956. Correspondence about the courses should be addressed to: Director, Venereal Disease Research Laboratory, Division of Special Health Services, PHS, Dept. of Health, Education, and Welfare, P. O. Box 185, Chamblee, Georgia.

DEATHS

RUFUS A. ASKEW, Atlanta, died July 5, 1955. He was 48 years old at the time of his death.

Born in Carrollton, Dr. Askew had lived in Atlanta since early childhood. He was a graduate of Atlanta Boys' High School, Northwestern University, and the Medical College of Georgia.

Dr. Askew was a member of the Protestant Episcopal Cathedral of St. Philip. He was also a member of the Sigma Chi Fraternity and several medical fraternities, and he had at one time served as physician for the Georgia Tech football team.

Survivors include his wife, the former Miss Mary

Lackey of Roswell; two sons, Anthony and Hulett; a daughter, Suzanna; three sisters, Mrs. Clyde Hargrett and Mrs. Charles Carter, all of Atlanta, and Mrs. Howard Sumlin, of Greenwood, S. C.; and a brother, Mr. Tom Askew, of Athens.

EDWIN S. BYRD, Atlanta, died July 7, 1955, at a private hospital in Atlanta.

Dr. Byrd was born in Norwood in 1892; he graduated from the Emanuel County Institute and received his M.D. degree from Emory University School of Medicine in 1914. He specialized in obstetrics, gynecology, and internal medicine. He was a member of the First Baptist Church.

During the First World War, Dr. Byrd served with the Army Medical Corps as a captain with the AEF in France. He was a member of the senior staff of Grady Memorial Hospital for 16 years and on the senior staff of Georgia Baptist Hospital for 21 years. He retired from active practice in 1945 because of illness.

Dr. Byrd is survived by his wife, the former Miss Lucy Bond of Enterprise, Ala.; sons, Mr. Edwin S. Byrd, Jr., Philadelphia, Pa., and Mr. Robert B. Byrd, Atlanta; and two grandchildren.

Funeral services were held on July 8, 1955, in the family cemetery, Enterprise, Ala.

W. L. CHAMPION, Atlanta's oldest practicing physician and the first urologist in Georgia, died July 2, 1955, in an Atlanta hospital. He was 88 years old.

Dr. Champion was born in Greene County and brought up in Eatonton. He graduated from the University of Maryland and practiced for one year in Eatonton before coming to Atlanta in 1893. He gave up his general practice in 1896 to specialize in urology, after graduate study in New York, France, and Germany.

Dr. Champion was first president of the Atlanta and Georgia Urological Societies. He had also served as president of the Fulton County Medical Society. He was a 33rd degree Mason, a member of Palestine Lodge, F.&A.M., Knights Templar, and a Shriner. He was also a member of the Southern Medical Association and the American Urological Association.

Survivors include his wife, the former Miss Sue Lou Harwell; one daughter, Mrs. Gene Nardin, Atlanta; and two grandchildren.

JOHN ALEXANDER CORRY, 78 year old Barnesville physician, died at his home on July 4, 1955, after a long illness. Funeral services were held the following afternoon at the First Methodist Church; burial was in Greenwood Cemetery.

Dr. Corry was a native of Greene County; he was educated at the University of Georgia and the Medical College of Georgia. He had lived in Barnesville more than 50 years, practicing medicine and taking part in many worthwhile community endeavors.

Dr. Corry served as chairman of the Barnesville Red Cross Chapter from 1919; he was a steward in the First Methodist Church for more than 20 years and was chairman for several years. He was chairman of the Lamar County Board of Health, and a former member of the State Board of Health.

As first president of the Barnesville Rotary Club he soon became known to Rotarians all over the state, and last October was honored with a special "John

(Deaths)

Corry" meeting where testimonials in praise of his life of service were heard from Red Cross officials, Rotary heads, churchmen, and representatives of the MAG and the State Board of Health.

Dr. Corry is survived by Mrs. Corry, the former Ailene Pitts; a daughter, Mrs. Ailene C. Arensbach, Atlanta; two sons, Mr. Jack Corry, Atlanta, and Mr. W. A. Corry, Akron, Ohio; and eight grandchildren.

JACKSON WILEY LANDHAM, Atlanta, died July 1, 1955, in an Atlanta hospital. He had been practicing in Atlanta for the past 35 years and was 71 years old at the time of his death.

Dr. Landham was born in Randolph County, Ala.; he was a graduate of the Emory University School of Medicine. A pioneer in the field of radiology and treatment with radium, Dr. Landham was a member of the Georgia Radiological Society and the Radiological Society of America.

He was also a Mason and a member of the Yaarab Temple of the Shrine. He was a member of the Second Ponce de Leon Baptist Church.

Funeral services were held on Sunday, July 3, 1955, at Spring Hill; burial was in Westview Cemetery.

Survivors include his wife; a son, Mr. Jackson Wiley Landham, Jr., of Griffin and Orlando, Fla; sister, Mrs. Benson M. Rucker, of Elmore, Ala.; two grandchildren; and several nieces and nephews.

FRANK BAXTER MITCHELL, SR., Crescent, died in a Savannah hospital on July 3, 1955, following an extended illness. He was 78. A native of Connecticut, Dr. Mitchell had practiced for many years in Macon before his retirement several years ago.

Dr. Mitchell is survived by his wife, the former Miss Matibel Pope; two sons, Frank B. Mitchell, Jr., Brunswick, and Col. William P. Mitchell, USMC; two sisters, Mrs. G. P. Bard, of Quitman, and Mrs. H. B. Mowry, of Rockledge, Fla.; and five grandchildren.

Interment was in Macon following private services.

SOCIETIES

The regular July meeting of the BLUE RIDGE MEDICAL SOCIETY was held at 7:30 p.m., July 14, at Harry's Club near Blue Ridge. Present were H. B. Hyde, McCaysville; Thomas J. Hicks, McCaysville; R. A. Burns, Blue Ridge; James M. Burdine, Ellijay; C. B. Watkins, Ellijay; C. B. Teal, Ellijay; Mr. H. A. Thornton, Manager of the Watkins Memorial Hospital, Ellijay; John R. McCain, Atlanta, guest speaker and Mr. John F. Kiser, of the MAG headquarters office.

Dr. Burdine, president of the society, presided at the meeting which included a fine steak dinner, and was followed by a talk by Dr. McCain on "Hypertensive Conditions in Pregnancy." Remarks were also presented by Mr. Kiser on activities of the MAG headquarters office. C. B. Watkins of Ellijay was elected to membership. All members of the society were invited to attend the opening ceremonies of the new hospital in Ellijay which were held on Sunday, July 17, at 2:00 p.m.

The CHEROKEE-PICKENS MEDICAL SOCIETY recently entertained the pharmacists of Canton at a dinner meeting at Pinecrest Inn in Canton. Ben K.Looper, Canton, presided. Dr. Melvin A. Chambers, Atlanta, dean

of the Southern College of Pharmacy, spoke on "Modern Medication—the Biggest Bargain in the Family Budget." He made the point that 90 per cent of the prescriptions today could not have been filled 10 to 12 years ago, because of the discovery and development of new drugs.

The organizational meeting of the FLINT MEDICAL SOCIETY, comprised of the physicians of Dooly and Crisp Counties, was held at 7:30 p.m. at the Crisp County Hospital, Cordele, July 12, 1955. Present were C. E. McArthur, Perry Busbee, O. K. Coleman, O. T. Gower, Jr., A. J. Whelchel, H. J. Williams, L. E. Williams, all of Cordele, and Martin Malloy, V. C. Daves, both of Vienna, and E. B. Davis, of Byromville. In addition were two new members, Joseph T. Christmas and Robert S. Robinson, both of Vienna.

The question of merging the two societies of Crisp and Dooly was discussed and it was voted by both groups to form the Flint Medical Society and to invite the physicians of Turner County to join this organization. C. E. McArthur, Cordele, was elected president, Martin Malloy, vice-president, and Perry Busbee, secretary. O. K. Coleman and O. T. Gower were elected delegate and alternate delegate respectively. H. J. Williams, V. C. Daves, and E. B. Davis were named to the Board of Censors. It was decided that meetings of the society will be held at the Crisp County Hospital at 7:00 p.m. on the second Tuesday of each month. Details of the organization concerning the program, time for the meeting, and meals, etc., are to be worked out at future meetings. After further discussion, there was a short talk by Mr. John F. Kiser of the MAG headquarters office. The two new members were voted on and were taken into the society. There being no further business the meeting was adjourned.

MUSCOGEE COUNTY MEDICAL SOCIETY, at a recent meeting, made plans to celebrate the society's 50th anniversary. James Elkins, Columbus, president, was in charge of the meeting. The program included a panel discussion on "Life Insurance, Investments, Wills, and Estates"; panelists included Mr. Claude N. Kent, Mr. W. H. Zimmerman, Mr. Forrest L. Champion, Jr., and Mr. Jerry W. Oliver. As part of the anniversary celebration, the society plans to publish a Golden Anniversary Edition of the *Bulletin of the Muscogee County Medical Society*.

WARE COUNTY MEDICAL SOCIETY is presenting this summer a series of radio programs dealing with problems of older people. The first program was aired on June 29th and the 13th and last program will be broadcast on September 21st. This series on gerontology was prepared and recorded by the AMA, and J. F. HOOKER, Waycross, is in charge of arrangements.

WARE COUNTY MEDICAL SOCIETY held its July meeting in Folkston; W. R. MCCOY, JOE JACKSON, and EUGENE A. MASON, all of Folkston, were hosts for the meeting. Mr. Leon Dunbar, associate manager of the Credit Bureau of Waycross, outlined plans for the establishment of a Medical and Dental Service Bureau in Waycross. He also showed a series of forms and illustrated how credit records are kept on individuals in their dealings with doctors and dentists for professional services.

PERSONALS

First District

C. Emory Bohler, Brooklet, has opened an office for the practice of medicine in the Minick Building in Brooklet. Mrs. Lurline Brannen, R.N., will assist Dr. Bohler in the office. Dr. Bohler is a graduate of the Georgia Teachers College, Statesboro, and of the Medical College of Georgia. He has recently completed his internship at the Columbia Hospital, Columbia, S. C. Dr. Bohler is a member of the Sigma Chi social fraternity and Theta Psi medical fraternity. He is married to the former Miss Billie Jean Parker, of Statesboro, and they have two daughters, Rene and Ellen.

J. HARRY DUNCAN, Savannah, has announced the association with him of Franklyn P. Bousquet, Jr., in the practice of ophthalmology. Dr. Duncan's office is located at 115 East Jones Street. A native of Worcester, Mass., Dr. Bousquet attended Worcester Academy; he received his A.B. degree from Dartmouth College and his M.D. degree from Tufts College Medical School. Dr. Bousquet interned at Worcester City Hospital and was assistant resident in surgery-ophthalmology at New York Hospital, Cornell University Medical School, 1948-50. The following year he was both resident and instructor in ophthalmology at the New York Hospital. Dr. Bousquet comes to Savannah from Detroit where he was an instructor in ophthalmology at Wayne University and senior associate in ophthalmology at Henry Ford Hospital.

W. V. Gillikin, who recently completed his internship at City Hospital, Columbus, has taken over the office in Twin City recently vacated by HUGH S. THOMPSON, now in the armed forces. Dr. and Mrs. Gillikin and their daughter arrived in Twin City on July 11 for residence.

SAMUEL YOUNGBLOOD, JR., Savannah, has been awarded a certificate of membership in the American Academy of General Practice, according to an announcement made by the president of the AAGP, John R. Fowler.

Second District

E. C. BRIDGES, Reynoldsville, has retired after practicing medicine in Seminole County for 49 years. Dr. Bridges is well known around this part of the country for his work in perfecting a cure for black widow spider bites and in curing pneumonia. Dr. Bridges still commutes to Donalsonville for a part-time office practice, and he and the people of Donalsonville feel that he has earned the right to "fish and look at my cattle and practice in my spare time."

Dr. and Mrs. GORDON CHASON, Bainbridge, celebrated their 50th Wedding Anniversary recently with a reception at their home in Bainbridge. Receiving with the Chasons were their daughter, Mrs. W. H. Miller, Mr. Miller, and their children, Mary and Gordon Chason Miller. Approximately 300 visitors called during the afternoon.

Richard Dickson, formerly of Columbus, has moved to Bainbridge to practice in association with the Riverside Hospital and Clinic. A native of Barker, N. Y.,

Dr. Dickinson received his education at Colgate University and the Tulane University School of Medicine. Dr. Dickinson has just completed his internship at Columbus City Hospital. Dr. and Mrs. Dickinson and their two sons, Ricky and Ray, are making their home at 821 Rose Circle, Bainbridge.

J. T. WRIGHT, Bainbridge, has closed his office at Donalsonville and has gone to do post-graduate work at Georgia Baptist Hospital, Atlanta.

Third District

The Vienna Lions Club held a reception on July 8th at the Leonard Memorial Hall honoring two new Vienna doctors and their wives. J. T. CHRISTMAS and R. S. ROBINSON have recently opened their offices in Vienna for the practice of general medicine. They are both graduates of the Medical College of Georgia and have just completed their internships at the Macon Hospital.

GEORGE M. HUTTO, Columbus, recently addressed a meeting of the Kiwanis Club in Columbus. He spoke on "Cancer—the Number Two Killer." Dr. Hutto noted that one out of every four persons will be a cancer victim, but one of the four victims will be cured and that as high as 50 per cent could be cured if they received treatment in the early stages of the disease. A film, "Your Cancer Society in Georgia," was also presented.

CHARLES MCARTHUR, Cordele, spoke to the Lions Club recently on "The M.D., a Citizen of Your Community." Dr. McArthur stressed the fact that the doctor is supposed to be a member of the community, that he "should and must do such as: vote, participate in various charities, fight crime, voice himself on political problems, and must be willing to do his part." OTHA COLEMAN, Cordele, was announced as a new member of the Kiwanis Club.

R. B. QUATTLEBAUM, Fort Gaines, has recently left the Fort Gaines Hospital and gone to Augusta for another year of study.

Homer P. Wood, formerly of Columbus, has recently moved to Fort Gaines as the first new doctor to have an office in the newly formed Clay County Hospital. Dr. Wood is a graduate of Emory University and the Emory University School of Medicine. He interned and had one year of residency at the Columbus City Hospital. Dr. Wood is a native of Roanoke, Ala.

Fourth District

E. JORDAN CALLAWAY and R. M. PATY, Covington, are now located in their new clinic on Tate Drive. The building, a modern brick structure just completed in July, is air conditioned and equipped with the latest facilities. Affiliated with Dr. Paty and Dr. Callaway is J. W. PURCELL, formerly of Atlanta, who began his practice in Covington on July 1, 1955.

J. M. MCKENZIE, Thomaston, and Mrs. McKenzie left on June 21, 1955, for a 10 week tour of England, Scotland, Sweden, Norway, France, and Italy. They arrived in Liverpool on June 28, their 50th Wedding Anniversary. Meanwhile, friends of Dr. and Mrs. McKenzie in Thomaston are making plans for a big reception and "Dr. McKenzie Day" when the physician

(Personals)

and his wife return from their tour. Dr. McKenzie has practiced medicine in Thomaston and Upson County for more than 50 years, and it is estimated that he has delivered more than five thousand babies.

THOMAS REEVE, formerly of Piedmont Hospital in Atlanta, has returned to Carrollton after an absence of two years. Dr. Reeve has been doing extensive study in surgery at Piedmont Hospital, and his practice will be limited to surgery. His office is at 619 Dixie Street.

Fifth District

CARL C. AVEN, Atlanta, has retired from the active practice of medicine after 45 years. At least he says he is retired, but his plans for the future include teaching at the Emory Medical School, teaching at Grady Hospital, and getting their tuberculosis unit set up. He also plans to devote more time to the TB division of the Fulton County Health Department; he is chief of staff of the Georgia Baptist Hospital; and he is general chairman of the Local Arrangements Committee for the 106th Annual Session to be held in Atlanta next May 13-16.

F. W. DOWDA, Atlanta, is now associated in the practice of internal medicine with CARTER SMITH, CHARLES F. STONE, JR., F. LEVERING NEELY, and EDWARD K. RUSSELL at 1210 Medical Arts Building, Atlanta. Dr. Dowda graduated from Emory University School of Medicine in 1949, and he received his postgraduate internal medical training at the Peter Bent Brigham Hospital in Boston and at Barnes Hospital, St. Louis.

A. H. LETTON, Atlanta, recently addressed the Austell Lions Club at one of the club's regular dinner meetings.

A portrait of the late LEWIE H. MUSE, Atlanta, was unveiled at a recent staff meeting of Crawford W. Long Hospital. The portrait was donated by Dr. Muse's friends and colleagues, and donations above the cost of the portrait will be used to establish the Lewie H. Muse Memorial Lecture Fund.

BOMAR A. OLDS, Atlanta, has returned to a limited office practice after undergoing a corneal transplant.

A new technique for injecting needles into joints has been developed by ARTHUR M. PRUCE, Atlanta, and Frank Netter, of East Norwich, Long Island, N. Y., was recently at Emory University to make sketches and notes for a series of illustrations he will do on the new technique. Dr. Netter is considered to be one of the world's foremost medical illustrators.

MORGAN B. RAIFORD, Atlanta, recently addressed the Atlanta Lions Club urging that more people will their eyes after death for cornea transplant operations. Following the talk Dr. Raiford showed a movie which described the operation of the Eye Restoration in New York City.

CHARLES B. UPSHAW, Atlanta, has been elected president of the Atlanta OB and GYN Society. The society was organized in June 1954 with R. A. BARTHELOMEW as its first president. JOHN B. CROSS, is the president-elect. At the meeting in June at which the officers were elected, JAMES MCCLURE, Atlanta, gave a paper entitled, "Temperature Observations in the Newborn."

JULIAN WAITERS, Atlanta, announces the association of ROBERT N. POOLE in the practice of pediatrics, and the removal of their offices to the Baptist Professional Building, Suite 146, 340 Boulevard, N.E., Atlanta.

CARL A. WHITAKER, THOMAS P. MALONE, JOHN WARKENTIN, RICHARD E. FELDER, ELLEN FINLEY KISER, and RIVES CHALMERS have resigned from the psychiatric teaching staff of Emory University School of Medicine. They are now associated in the practice of psychiatry at 1293 Peachtree Street, N.E.

Sixth District

C. STERLING JERNIGAN, Sparta, was painfully though not seriously hurt when his car collided with another car the early part of July.

T. C. JORDAN, formerly of Thomaston, has joined the staff at the Richard Binion Clinic, in Milledgeville, it has been announced by CHARLES B. FULGHUM. Dr. Jordan received his M.D. degree from the Medical College of Georgia and interned at the Macon Hospital. He practiced for a short time in Barnesville and then returned to the Macon Hospital to complete his surgical residency. He goes to Milledgeville from Thomaston, where he was on the surgical staff at the Hill-Burton Hospital.

C. G. MOYE, Dublin, and Mrs. Moye were seriously hurt in an automobile accident on June 25th. The accident was a head-on collision near Starke, Fla.; Dr. Moye suffered a crushed leg and internal injuries, and Mrs. Moye suffered internal injuries. They were on their way to Palatka to visit their son, Mr. Victor Moye.

EDGAR M. POPE, Macon has accepted the appointment of chief of the otolaryngological division of the Veterans Administration District at Des Moines, Iowa. A native of Macon, Dr. Pope was graduated from Mercer University and the Medical College of Georgia. He practiced in New York from 1925 until 1943 when he returned to Macon to enter private practice.

Seventh District

Noah D. Meadows, formerly chief resident of the City Hospital of Winston-Salem, N. C., has opened offices at 317 Atlanta Street, Marietta, for the practice of internal medicine. A graduate of Emory University, Dr. Meadows served two years on the staff of the VA Hospital in Atlanta.

CHARLES W. STEPHENSON, Ringgold, has been presented the "Outstanding Citizenship Award" in a plaque given by the Boynton Lions Club, naming him as the citizen who had contributed most in civic work throughout Catoosa County. Dr. Stephenson is a member of the Board of Directors of the Tri-County Hospital, he was first chief of staff of the hospital; he is a fellow of the AMA; fellow of the AAGP; and a member and past president of the Tri-County Medical Society.

Eighth District

CECIL F. JACOBS, formerly of Augusta, is the newest member of the staff of the Leaphart Hospital, Jesup. Dr. Jacobs received his pre-medical training at The Citadel, Charleston, S. C., and he is a graduate of Medical College of Georgia. Dr. Jacobs has practiced for

some time in Augusta and will engage in the general practice of medicine and obstetrics in Jesup.

Ninth District

Grady F. Duke, formerly of Atlanta, has recently gone to Buford to practice medicine and surgery. Dr. Duke is a native of Alabama; he graduated from the University of Alabama and received his M.D. degree from Jefferson Medical College of Philadelphia in 1953. He has undergone postgraduate training in surgery at Georgia Baptist Hospital in Atlanta for the past year.

THOMAS N. LUMSDEN, formerly of Helen, is now associated with JESSE L. WALKER, CHARLES M. HENRY, and L. G. HICKS, with offices in the Habersham Medical Building, Clarkesville. Dr. Lumsden is a graduate of Emory University and Emory University School of Medicine. He interned at Grady Memorial Hospital and served two years in the Army Medical Corps in Germany. After his military service, he took a year's training in surgery at the VA Hospital in Atlanta, following which he practiced in Helen.

Samuel O. Poole has recently opened his office in Gainesville for the practice of internal medicine and cardiology. He will be associated in partnership with HENRY S. JENNINGS at 608 East Broad Street. Dr. Poole is a native of Americus and a graduate of Emory University School of Medicine. He interned at Barnes Hospital, St. Louis, and went to Grady Memorial Hospital, Atlanta, as assistant resident in medicine. After two years' service in the Army, he returned to Grady as senior resident in medicine and for the past 12 months has been clinical fellow in cardiology, Emory University School of Medicine. Dr. Poole is married to the former Miss Bess Sheppard, of Waynesboro, and they have two children, Sam, Jr., 4, and Julie, age six months.

Tenth District

JOHN L. CHANDLER, JR., Augusta, announces the removal of his office to Room 409, Medical Arts Building, 1467 Harper Street, for the practice of orthopedics.

J. Fred Denton, Augusta, associate professor of medical microbiology at the Medical College of Georgia, is in San Jose, Costa Rica, on a China Medical Board fellowship in tropical medicine and parasitology. He left Augusta on June 29th and will remain in Costa Rica through August.

G. LOMBARD KELLY, Augusta, announces the removal of his office to the Medical Court, 1445 Harper Street.

William H. Moretz, formerly of Salt Lake City, has been appointed professor of surgery and chairman of the Department of Surgery at the Medical College of Georgia. A native of Hickory, N. C., Dr. Moretz received his B.S. degree from Lenoir Rhyne College; he is a graduate of Harvard Medical School. His internship and residency in surgery were taken at Strong Memorial Hospital, University of Rochester School of Medicine, Rochester, N. Y., and he was subsequently instructor in surgery at the same institution. From 1944 to 1947, Dr. Moretz served with the U. S. Army as Assistant Chief of Neurosurgery at Cushing General Hospital and as Chief of General Surgery at Hallo-

ran General Hospital. In 1947, he was appointed assistant professor of Surgery at the University of Utah College of Medicine, and two years later was promoted to associate professor of surgery, which position he has held until the present time.

POMEROY NICHOLS, Augusta, is chairman of the advisory committee of the Richmond Muscular Dystrophy Chapter; seven other members of the Richmond County Medical Society were also named to serve on the committee, they are as follows: W. N. AGOSTA, A. S. CARSWELL, LOUIS O. J. MANGANIELLO, JOHN A. FAULKNER, D. F. MULLINS, JR., JAMES BENNETT, and THOMAS E. BAILEY.

CAROL GRAHAM PRYOR, Augusta, has recently been certified by the American Board of Obstetrics and Gynecology. On August 1st, she moved from her office at 1333 Harper Street to the new Medical Arts Building at 1467 Harper Street, Augusta.

Walter Gowans Rice, formerly of St. Louis, has been appointed Associate Professor of Pathology at the Medical College of Georgia. Dr. Rice was born in Paiko, Nigeria, West Africa, and is a naturalized American citizen. He received his M.D. degree from the University of Toronto in 1938. He came to the United States in 1948 as pathologist at the King's Daughters' Clinic in Temple, Texas, and then was assistant pathologist at Baylor University Hospital and instructor in clinical pathology at Southwestern Medical College in Dallas, Texas. In 1950 he went to St. Louis University School of Medicine as assistant professor of pathology. In 1953 he was made Director of the School of Medical Technology of St. Louis University and director of the hospital laboratories, St. Mary's Group of Hospitals in St. Louis. He is certified in pathological anatomy and clinical pathology, and has passed the American Board of Pathology.

J. VICTOR ROULE, Augusta, announces the removal of his office from the Southern Finance Building to the Medical Arts Building, 1467 Harper Street.

WILLIAM A. STEED, Augusta, announces the removal of his office from 305 Tenth Street to 1122 Druid Park Avenue.

WILLIAM O. WHITE, Augusta, announces the removal of his office to the Medical Arts Building, 1467 Harper Street.

News From The Southern Medical Association

More than half of the sections are in the formative plans for the Houston Meeting, and many are complete. August the 15th is the deadline, and the home office is awaiting information from Anesthesiology, Industrial Medicine and Surgery, Neurology and Psychiatry, Public Health, Surgery and Urology in order that all sectional meetings can be arranged.

Word has been received that the insurance program will be accelerated. The SMA plan is now the most flexible of all insurance programs in any medical organization. Drop a line to the Secretary for a brochure, if you have not received one.

The LAST CALL for Shamrock reservations is at hand. If you intend or want to stay at this hotel during the meeting November 14-17, then write Mr. Foster today!

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1955 by the Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; 1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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Cover picture of a technician running an electroencephalogram was taken by Ted F. Leigh, M.D., *Journal* Photography Editor.

106TH ANNUAL SESSION

May 13-16, 1956 — Atlanta Biltmore Hotel

LAST CALL for SCIENTIFIC PAPERS



Titles of papers should be submitted immediately to the respective program chairmen listed below.

All titles must be submitted before September 30, 1955

Thoracic Medicine

C. C. Aven, M.D.
384 Peachtree St., N. E., Atlanta

Trudeau

C. C. Aven, M.D.
384 Peachtree St., N. E., Atlanta

Surgery

Duncan Shepard, M.D.
1211 West Peachtree St., N. E., Atlanta

General Practice

John Hines, M.D.
Roswell

Medicine

A. Park McGinty, M.D.
762 Cypress St., N. E., Atlanta

Heart

A. Park McGinty, M.D.
762 Cypress St., N. E., Atlanta

Pediatrics

John Leslie, M.D.
518 Marshall St., Decatur

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MAG Committee Round-Up

IN CITING PROGRESS toward improving the health and welfare of the citizens of Georgia, the Medical Association of Georgia has some 26 committees to develop and improve the standards of professional medical care. These committees, carrying out the mandates and policies of the MAG House of Delegates and Council, solidly represent your Association's activity. Each committee submits an annual report with recommendations to the House of Delegates, and during the ensuing year strives to fulfill its objectives. This "MAG Committee Roundup" is a mid-year report to the members on the activity to date of the committees having already begun their 1955-56 program.

Scientific Work

The Scientific Work Committee, responsible for the planning and programming of the 1956 Association Annual Session to be held *May 13-16, at the Atlanta Biltmore Hotel* has met twice with the specialty society chairmen to plan the scientific section meetings. Arrangements have been made for approximately 70 commercial exhibits and 30 scientific exhibits. Tentatively the session will begin Sunday, May 13, at 2:00 p. m. with section meetings. The House of Delegates will convene at 5:00 p. m. followed by specialty society dinners Sunday evening. Monday morning a general session sponsored by the general practitioners is slated. Monday morning is the traditional time for the general business session followed by specialty society luncheons, and section meetings are scheduled for Monday afternoon. Monday evening will be given to a medical-religious program sponsored by the GP's. Tuesday morning's section meetings will be followed by specialty society luncheons. On Tuesday afternoon the House of Delegates will meet, and a general meeting will be held for other members. Tuesday evening is the occasion of a social hour and President's Reception and dance. Wednesday morning a joint memorial service and general business meeting are scheduled. To effect this, the Scientific Work Committee is coordinating the work of 16 specialty societies and the Fulton County Medical Society Local Arrangements Committee.

Legislation Committee

As evidenced by the 1954-55 report of this committee, you have been well represented on both the federal and state legislature levels. The Legislation

Committee will meet in October to consider new and pending legislation related to the medical profession. The committee's aim is to have the profession actively engaged in designing and supporting the best medical legislation in the public interest, and the committee plans to sponsor legislation at the January 1956 session of the General Assembly. It is well to emphasize that the committee's *real strength lies in your support of their program*, and you will be called upon to *stand for* the issues the committee promotes.

Medical Defense

The Medical Defense Committee with the cooperation of the Association's attorney, Mr. John Dunaway, has been increasingly active in representing the membership in professional liability problems. Each member receives the privilege of medical defense by the Association's attorney should the need arise, and this committee has done and continues to do a splendid job in representing MAG members.

Public Health

Recently reorganized, this committee is made up of the chairmen of 11 Association committees. The Public Health Committee acts as a central "clearing house" to coordinate and correlate the 11 MAG committees whose work has to do with the broad field of public health. The Public Health Committee will meet within the next two months to evaluate the work of these 11 committees and make its recommendations to the committees through its chairmen members.

Maternal and Infant Welfare

An ambitious program of surveying each maternal and infant death occurring in Georgia is now in progress, and the committee will publish the results of this survey in the next few months. Physicians have cooperated in making this survey possible and in almost all of the instances of maternal or infant mortality, the attending physician has requested the committee's evaluation of the case. The committee in assessing these cases records them as (1) preventable; (2) non-preventable; or (3) insufficient information, and then in the case of preventable mortality reports to either the physician, hospital, public health department, or the community at large as an educational measure designed to remedy the preventable cases. The committee has also concerned itself with post graduate education to further improve maternal and infant welfare.

Constitution and By-Laws

A completely revised Constitution presented by this committee was given its first reading at the May 1955 House of Delegates meeting, and the committee is now preparing a "word by word" complete revision of the by-laws for presentation to the 1956 House of Delegates. Long needed by the Association, this tremendous revision will give the Association a document that is in keeping with the progress and present trends of the organization.

Public Relations

The Public Relations Committee has largely devoted its efforts to district conferences for county medical society presidents and secretaries. These conferences have been held in four districts to date and are planned for the other six districts; a conference will be held in each district before January 1956. Object of the conferences is to give data to the officers of the component county medical societies in an effort to stimulate better county medical society public relations and to effect closer liaison between the county society and the MAG. The programs have been well received and are believed to be of great value.

Rural Health

Of the many projects undertaken by the Rural Health Committee, those completed to date include two successful medical school "Senior Day" programs, effective inauguration and supervision of the MAG Physicians' Placement Service, publication of a booklet "So Your Town Needs a Doctor" designed to give a community data on how to attract a physician, and investigation concerning the establishment of general practice departments in Georgia's two medical schools.

Insurance Board

The Insurance Board has completely revised the present Georgia Plan of prepaid medical care insurance, and the revision will be ready in a few months. The plan will have features which will provide better coverage for the patient and which, at the same time, make the plan more attractive to participating physicians. The board has also put into operation a professional liability program for MAG members that is far superior to the older type of malpractice coverage in that the doctors themselves will jointly administer the plan with the St. Paul Mercury Insurance Company. The board is also investigating types of "catastrophe" insurance for the general public, and the board has made available to MAG members a group life insurance plan and a group health and accident policy.

Hospitals

The Hospitals Committee is working on the publication of a "Minimum Standards Guide" for the

professional side of the operation of under-25-beds hospitals. This guide will list certain minimum standards to be used as a guide for the many small hospitals in Georgia. These standards will be realistic and can effectively aid small hospitals in setting up staff, organization, and rules of M.D. procedure.

Mental Health

Meeting last month at Milledgeville State Hospital, the Mental Health Committee surveyed conditions at the hospital. The committee will also study general aspects of treatment of mentally ill persons in Georgia. The committee plans to inaugurate an educational program, both within the profession and for the general public, on the needs of mental health care in the state. In addition, the committee will formulate policy recommendations in this field for Association consideration.

Other Committees

Other committees actively functioning in the Association members' behalf are: Woman's Auxiliary Liaison; Awards; Industrial Health; Cancer; Blood Banks, and Crippled Children. It is well to note from this list that never before in the Association's history have so many of its committees been active and held regular meetings.

Council

The Council of the Medical Association of Georgia, charged with the responsibility of carrying out the mandates and policies of the Association, has met to consider long agendas with almost 100 per cent attendance. Two special meetings were held by the Council in addition to the regularly scheduled quarterly meetings. Council, formerly convened for one day meetings, now requires two days to consider the many Association problems brought before them at their meetings. The individual physicians serving on the MAG Council have put the Association's interest foremost and have unselfishly devoted their time to service in the profession.

Summary

Presented on this page is a brief resume of MAG committee activity during the year 1955-56 to date. The conclusion is that the year 1955-56 shows promise of being the Association's most progressive—and some six months still remain for further committee activity. The Association's officers, cognizant of this progress, wish to commend those members responsible, and Association members are well aware of the work being done in their behalf. It is incumbent upon Association members to "pull together" and support the achievement of the Association committees.

Milton D. Krueger
Executive Secretary

The Medicolegal Aspects of Head Injury

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THE PROBLEM PRESENTED by the allegedly head-injured litigant is often a difficult one for all concerned. This is especially true for the neurological surgeon or other expert medical witness who may be asked to evaluate not only the claimant's presenting complaints but his pre-injury state, the possible and probable effect of the alleged injury, and prognosis as well.¹ In the present age, high speed travel, industrialization, and extensive liability and workmen's compensation insurance have resulted in a great increase in the number of cases requiring such testimony. Relatively little has been written on the medicolegal aspects of head injuries,^{2 3 4 5 6} and one is left much to his own devices and painfully acquired experience. In his brief presentation I propose to outline the current methods of clinical investigation and indicate their broad legal implications.

Understanding of the pathological states resulting from violence to the head requires a knowledge of the applied force, the structures involved, and the mechanism by which the force affects them.^{6 7} Consider then the human skull as being a nearly rigid bony box containing an infinitely delicate and complex semi-solid network of nerve cells and fibres suspended in a watery bed, the cerebrospinal fluid. The cranial cavity and its contents are separated into compartments by tough dural folds and bony ridges. Experimental and clinical studies indicate that the great variation in pathology following head injury depends much upon the nature of the force (whether "blunt" or penetrating), its direction, and upon the degree of mobility of the head at the moment of impact. Closed head injuries are more frequent than penetrating ones in civil practice and may cause severe or even fatal brain damage with little external evidence of injury.⁸ This serves to emphasize the clinical axiom that fractures of the skull are usually

of less practical import than the damage sustained by its contents, a view not widespread among the laity.

Fractures of the skull may be localized to the point of impact or follow lines of least resistance in a bursting effect. Depression or compounding may add complications of sepsis and compression. When these fracture lines involve the foramina of the cranial nerves, the middle ear or paranasal sinuses, cranial nerve palsies, cerebrospinal fluid fistulas with meningitis or pneumoencephalocoele may result. Laceration of meningeal arteries and venous sinuses at times gives rise to epidural hematoma. Basilar fractures can be produced by blows to the jaw, face, and spine.

The meninges and brain may suffer damage not only from application of direct force but from sudden rotation and linear acceleration. This results from the inertia of brain which causes violent contact with skull and dura as the skull moves. Conversely, sudden linear deceleration of the skull causes the still-moving brain to be thrown against those structures. Torsion or contusion of brain stem and subcortical regions is thought to underlie disturbance of consciousness resulting from head injuries.^{8 9} Concurrent tears in arachnoidal membranes give rise to subdural hygroma. Rupture of bridging veins or venous sinuses is considered to be the most frequent source of subdural hematomas.

Brain injuries sustained include concussion, contusion and lacerations, and intracerebral hemorrhage. Concussion has been defined as a direct traumatic paralysis of nervous function without vascular lesion which is immediate, proportional to severity of injury, and reversible. It is characterized by unconsciousness with amnesia for that period. It has been attributed to physical submicroscopic injury to the neurones.^{9 10} The cerebrospinal fluid is clear. Cerebral contusion and laceration represent more severe injury with varying pathological and clinical residual.

Presented at the 104th Annual Session of the Medical Association of Georgia, Macon, Ga., May 2-5, 1954.

Especially prominent about the frontal and temporal poles, the lesions involve both grey and white matter of cerebrum and brain stem. Although contusion may be present without laceration, they commonly occur together. The cerebrospinal fluid is bloody. Intracerebral hematomas may develop insidiously and are often associated with contusion and laceration.

The procedure employed in evaluating head injuries depends upon the stage of the injury. In the acute phase of injury the clinical picture is less likely to be complicated by extraneous factors than later. The first step is obtaining and recording a detailed history of the alleged injuries not only from the patient but from any others who can contribute. Date and time of injury, manner of occurrence, and, if possible, a description of the forces involved are recorded. The occurrence of hemorrhage from orifices, vomiting, and seizures should be noted. Particular attention should be paid to alterations in consciousness resulting from the injury: was the patient unaffected, dazed, or unconscious? If unconsciousness is alleged to have occurred, the duration of retrograde and post-traumatic amnesia are ascertained. Retrograde amnesia is that memory loss for events prior to injury; post-traumatic amnesia is that occurring from the moment of injury to the return of "continuous remembering".¹⁰ Although both may be absent in severe injuries, their occurrence gives an index of the severity of generalized disruption of cerebral function. In this connection, post-traumatic amnesia has been found to be a better index of brain damage than retrograde amnesia and one of the best available. Retrograde amnesia may diminish or clear during recovery, but the duration of post-traumatic amnesia remains remarkably constant. The medicolegal importance of this finding is evident. The subsequent course of events should be ascertained in detail.

The physical examination should include observations of the vital signs, the state of consciousness and pupillary reactions, and any evidence of nuchal rigidity or external violence to the head. Bleeding from ears or nose or cerebrospinal rhinorrhea suggests basilar skull fracture. A complete neurological examination should be done, if possible, and all findings recorded in detail. This is especially important in the acute stage of injury since it forms a baseline for comparison with all future examinations. Gross alterations in motor and sensory function, in affect and cranial nerve function are recorded. Concurrent injuries to other parts must not be overlooked.

Extensive X-ray examination may be contraindicated in the acute stage of injury, but a single lateral portable film of the head and neck can be made without dangerous manipulation of the patient to

evaluate major cranial damage and exclude associated injury to the cervical spine. Plain skull films should be made later, especially when medicolegal complications are anticipated. The nature of subsequent studies will depend on the presenting problem. Ventriculography may be indicated in the presence of increased intracranial pressure, pneumoencephalography in its absence. Minor asymmetries in the ventricular system may have no pathological significance, but progressive enlargement of the system without evidence of obstruction is more suggestive of brain atrophy induced by trauma.¹¹ Arteriography may be useful after acute vascular damage has subsided.

Examination of the cerebrospinal fluid is of little clinical value except to verify the presence of subarachnoid bleeding following cerebral contusion and laceration. It is of greater medicolegal importance in that it furnishes objective evidence of those states of brain damage.

Increasing availability and use of clinical electroencephalography has added another laboratory aid in evaluation and prognosis in head injury. Intense interest stimulated by civil and military head injuries has produced extensive accounts of EEG changes in all stages of head injury.^{12 13 14 15} As an objective record of electrical activity of brain, it undergoes well-established disturbances in trauma. The degree of EEG abnormality has been found to correlate well with other evidence of brain damage, particularly in the acute stage of injury, and to be of value in prognosis. A normal EEG in the post-traumatic state does not exclude brain damage but suggests either that none was sustained or that it is resolved. The presence of EEG abnormality in a patient who has allegedly suffered head injury does not necessarily confirm that allegation, since some five to 10 per cent of "normal" persons have some EEG disturbance. Serial records depicting progressive improvement in the EEG after head injury lend more weight to the assumption that the abnormalities were caused by the head injury. The finding of persistent EEG abnormalities does not alone contraindicate return to full activity. Although of aid in locating intracranial hemorrhage, it is less reliable than air studies and arteriography. In differentiating between functional disorders and epilepsy in post-traumatic states, especially in those complicated by litigation or desire for compensation, the EEG has proven helpful and, at times, decisive.

Aside from general supportive measures, the primary surgical concerns in the acute phase of injury are the prevention of infection and the relief of cerebral compression. Thereafter the patient passes through a period of steady improvement, the stage of recovery. This convalescence ends after a variable

period when no further improvement is apparent. The time required is influenced by a number of factors, but the extent of brain damage is generally conceded to be the most important. Although most patients require no more than three months to reach equilibrium, more than a year may be necessary, a point to be remembered in evaluating permanent residuals of injury.

The third stage is that in which the "permanent" post-injury level of function is attained. The patient, if not a willful liar or malingerer, is quite naturally apprehensive over his injury and his prospects of future adjustment to real or fancied incapacity. This state is frequently intensified by financial and domestic worries, dire predictions from relatives and friends, and by compensation claims and litigation. The all-too-familiar picture of the "post-traumatic syndrome" emerges. The patient complains of headaches, dizziness aggravated by postural changes, insomnia, difficulty in concentration, memory impairment, and visual disturbances. When the relatively small group with symptoms due to chronic subdural hematoma or cervical disc damage^{16 17} are excluded, most of these patients evidence few positive physical findings. Follow-up studies of large numbers of patients with both open and closed head injuries have yielded some interesting observations on this syndrome.¹⁸⁻²⁰ It occurs most frequently in persons who have by all available criteria suffered less severe head injuries and who have experienced either brief unconsciousness or none. Further, its incidence is greater in those persons with personal or family histories of pre-injury personality inadequacies and correlates better with these factors than with desire for compensation.²¹ Injury provides an escape from tedium and responsibility for such persons, a state often not gladly surrendered despite generous monetary compensation. Frank malingering and fraud are rated in comparison to frequent purposeful exaggeration of complaints for gain. The severity of these symptoms tends to increase with litigation and repeated medical evaluation as therapy becomes progressively more difficult. Although settlements terminate many complaints, there are those persons who are unaffected either by the "golden ointment" or by medical therapy. Many of them have a history of pre-injury maladjustments of personality inadequacies.

Residual cranial nerve deficits are found in the III, IV, VI, I, II, and VII in that order of frequency¹⁸ and may be tested appropriately. Focal motor, reflex, and sensory residuals can be differentiated from functional disturbances and malingering on clinical grounds.

Intellectual deterioration as a result of head injury

does occur but is surprisingly rare.²² The injury necessary to give rise to it must be of severe degree with coma and is in most instances accompanied by other neurological deficits. Psychometric testing is essential where this state is alleged and this data is compared with any information on the patient's pre-injury capacity.²³ Mild changes in personality must be distinguished clearly from true intellectual deterioration. The interesting observation has been made that many intellectual "deficits" in these persons do not extend to calculation of compensation or testifying in one's behalf in court.²⁰

The question of post-traumatic epilepsy receives much attention in litigation after head injuries.^{2 24 25 26} The incidence of post-traumatic epilepsy in a series of unselected closed head injuries is reported about 2.5 per cent whereas with open injuries ranges of 5.5-20 per cent have been noted. After simple concussion such seizures are almost unknown. With good anticonvulsant therapy the seizures may cause little disability, but the social and economic handicaps imposed are unfortunately still severe. This is reflected in large compensation settlements made upon these sufferers. Knowledge of this has led some unscrupulous litigants to deny seizures prior to injury despite long-standing and well documented histories of epilepsy. The differentiation of true seizures from psychogenic disturbances and malingering is of crucial importance in this connection.

In the final estimate of disability from alleged head injury there are no simple criteria. It is evident that the mere existence of demonstrable neurological disturbances in such persons does not prove that they are due to the alleged injury. It is necessary to ascertain that these did not exist prior to injury, often a difficult thing to do. The relative role played by the functional and the structural elements of complaints must be determined as fairly as possible. Though justice requires compensation of genuine disability, personal inadequacies are not compensable. The end result of the injury is determined by interaction: (1) the pre-injury state (or constitution) of the individual, (2) the severity of the injury, (3) the motivation of the patient to resume activity and responsibility, and (4) compensation and litigation factors. The following case reports will serve to illustrate some of the points:

Case I

Mrs. V. A., a 33-year old housewife, was admitted to St. Joseph's Infirmary on December 12, 1953, in a confused state. Five hours before, while crossing the street, she was struck by an automobile and received a two-inch laceration in the left parietal scalp. She was apparently rendered unconscious for a few minutes and was seen in the emergency room of another hospital 20 minutes later. At that time there were no positive neurological findings except for confusion as to her activities during the eight hours preceding her injury. There was a 30 to 60 minute retrograde amnesia. She was oriented to person and responded to commands. After closure of the laceration she

was transferred to St. Joseph's Infirmary for observation and further treatment. The neurological examination was not remarkable except for anxiety and mild confusion. She was disoriented to place, partially to time, but not to person. There was some tenderness over the left clavicular region. X-rays of the cervical spine and skull were normal except for minimal roto-scoliosis of the spine with convexity to the right suggesting muscle spasm of the left side of the neck. There was a complete transverse fracture of the outer end of the left clavicle without displacement. The following day she was mentally alert and clear, and she was able to recall the events of the preceding day up until a few minutes before she was struck. She did not remember her hospital admission six hours before but remembered everything since waking that morning. The duration of her post-traumatic amnesia was estimated at six to eight hours. Lumbar puncture yielded clear, colorless cerebrospinal fluid under normal pressure. It contained five white blood cells, 25 mgm.% total protein. Kahn and colloidal gold were negative. During the next three days she improved rapidly. Sutures were removed on the fourth hospital day. The shoulder was strapped by the attending orthopedist, and she was discharged free of complaints except for a mild headache in the frontal regions on standing. She was discharged on December 16, 1953, with a diagnosis of cerebral concussion, laceration of the parietal scalp, and simple fracture of the left clavicle. She returned for a follow-up visit on December 22, 1953, and had no complaint except for mild frontal headaches morning and evening and some shoulder pain on the left. She was neurologically intact, and the wound was well healed. She asked to return to work, and permission was given. She was told to return in 30 days for follow-up. During the following week litigation began. She returned on February 4, 1954, and complained of dizziness and headache which were more pronounced on stooping, paroxysmal episodes of numbness in both legs, and acute episodes of weakness and exhaustion. She appeared very tense, anxious, and greatly distressed. Neurological examination was within normal limits. An EEG on February 11, 1954, was within normal limits (Figure 1). An opinion was rendered that there was no evidence of permanent structural disease to the nervous system. On last account the case was still pending and other neurological opinions were being sought.

Case II

Mr. J. S. R., a 61-year old right-handed telegraph company supervisor, was admitted to St. Joseph's Infirmary on June 19, 1953. At 4:30 A. M. of that day he was awakened from his

sleep by repeated hammer blows on the left side of the head administered by his wife in a homicidal psychotic state. He was dazed but not completely unconscious and managed to halt the attack and get help. He was assisted to the hospital, able to walk and respond. On physical examination he was oriented, drowsy, and hiccuping. Blood pressure was 130/70, the pulse 64, and respirations 20. There were several lacerations in the left temporal and frontal regions. There was a marked ecchymosis over the left eye and edema of the left scalp. The deep tendon reflexes were 3+ on the right, 1+ on the left, and there was a questionable extensor plantar response on the left. Sensory examination was apparently normal. X-rays of the skull showed a large comminuted, depressed fracture of the left frontal temporal region. It was eight centimeters in diameter and was depressed two and one-half centimeters. Emergency craniectomy was done with debridement of the scalp wounds, lacerated temporal muscle, and removal of numerous bone chips. The middle meningeal artery was severed in three places, and there was a small epidural hematoma. The fracture line was seen to extend into the anterior fossa. The dura was lacerated, and the temporal cortex was grossly contused. His postoperative course was quite satisfactory. The sensorium cleared so rapidly that in 48 hours there were no localized neurological findings. The wound healed cleanly by the end of the first week. He repeatedly expressed anxiety over his wife's health and his desire to return to work. He never volunteered any complaint concerning his own condition except that of mild impairment of memory. He was discharged otherwise asymptomatic on the twelfth hospital day. On his return for follow-up visit two weeks later he had no complaints except for some difficulty in recent memory. He again expressed the desire to return to work as soon as possible. There were no positive neurological findings. On August 7, 1953, an EEG showed focal electrical abnormality over the entire left Sylvian region (site of maximal contusion) accentuated by hyperventilation (Figure 2). The right side was normal. One month later he returned to full activity and has continued so since, free of complaint.

These contrasting states require little comment. There are many instances in which the distinction is not so finely drawn between the structural and the psychogenic factors, and the final analysis will show a varying proportion of each.

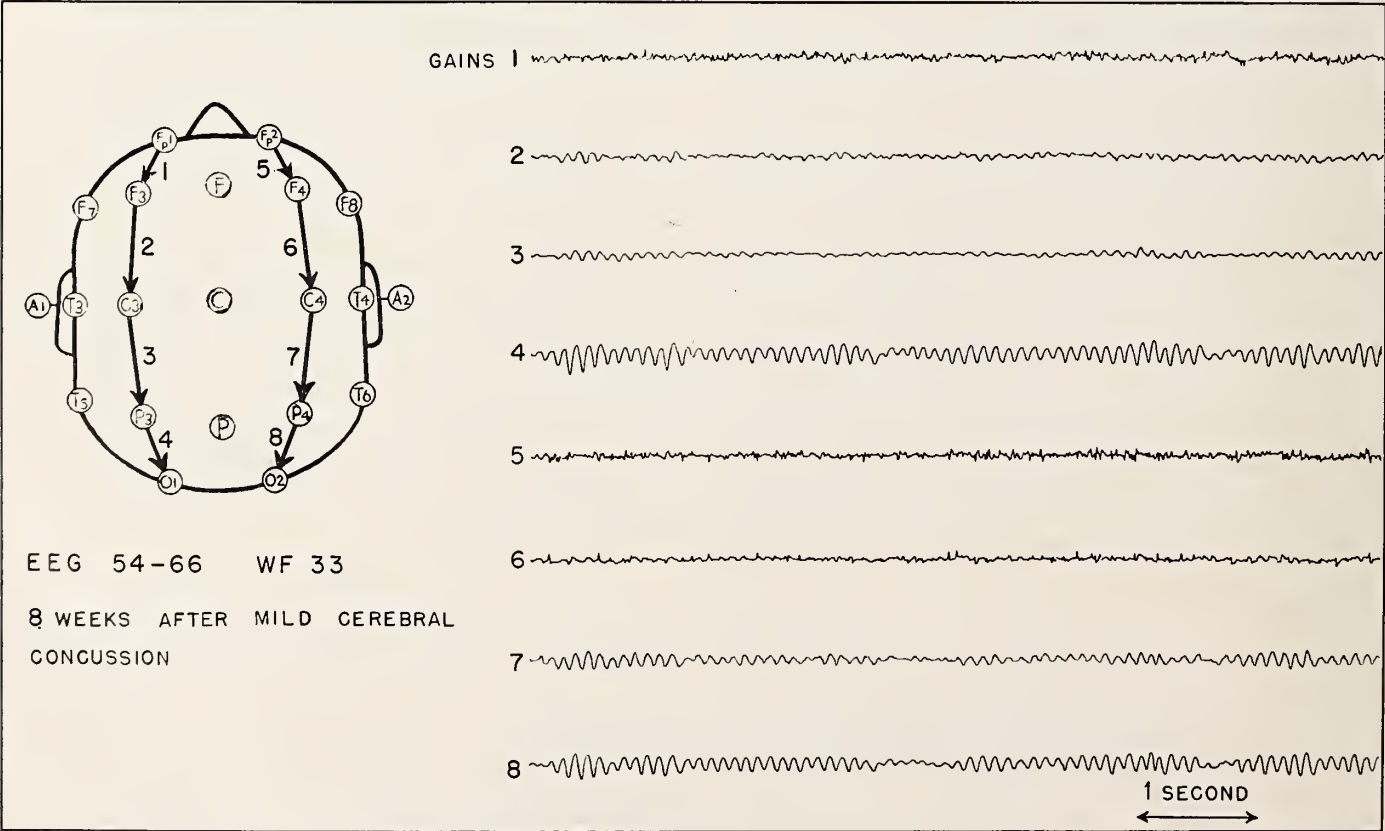


Figure 1

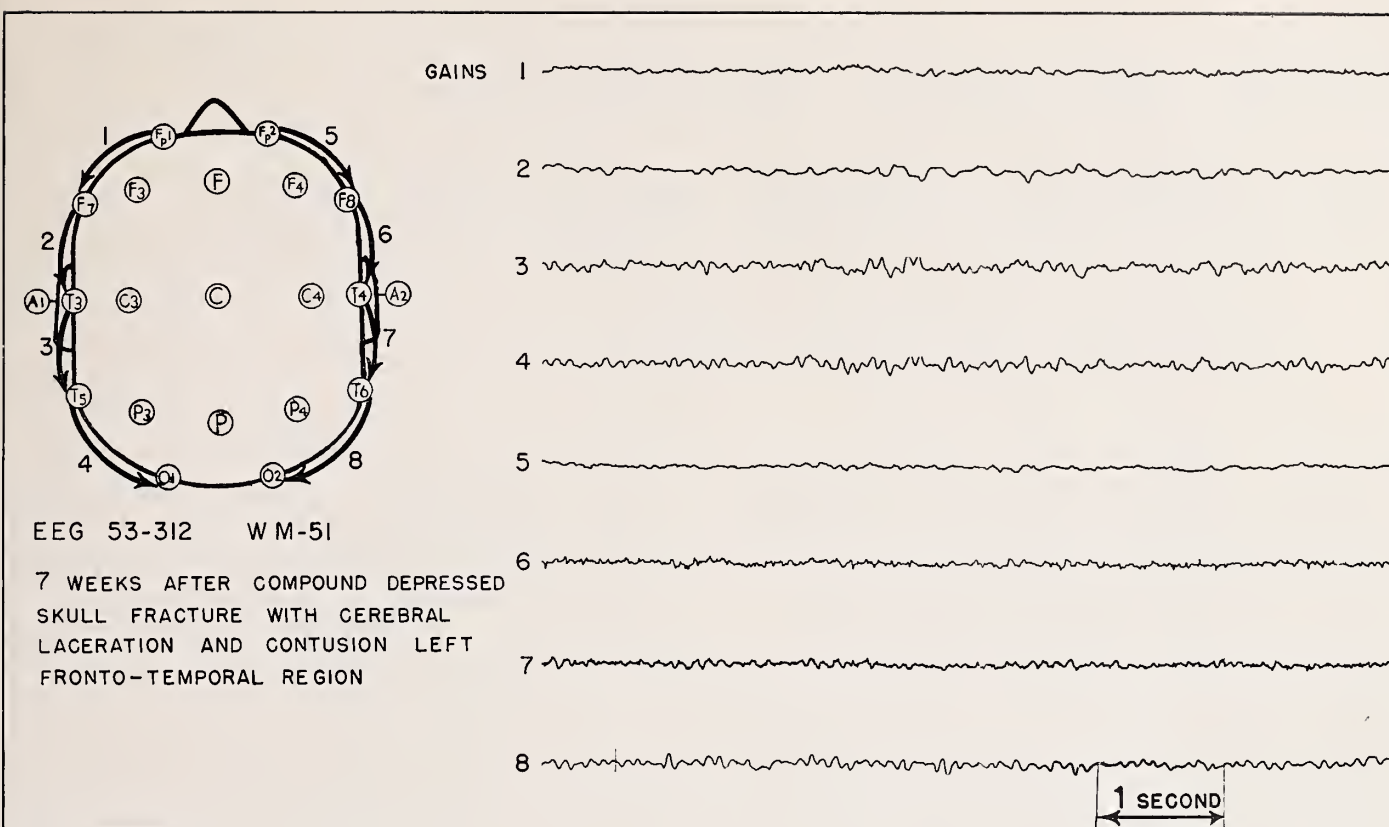


Figure 2

The final estimate of central nervous system disability due to injury is based upon the degree of success with which the patient can function in situations requiring normal capacity. As already intimated, the law does not require the defendant to assume financial responsibility for that portion of disability attributable to the claimant's pre-injury state, either structural or psychogenic, but only for traumatically-induced demonstrable deficits or aggravation of pre-existing states.²⁷ The court must rely heavily on testimony of the expert witness. In supplying an impartial and competent opinion, the ethical physician, no less than the ethical attorney, is a good officer of the court.

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Stress, Exertion, and Death in Coronary Artery Heart Disease

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THE PROBLEM of stress, exertion, and death in coronary artery disease is a most important one; it is highly controversial with, in many instances, significant medicolegal connotations. In the past, a diagnosis of coronary artery disease was attended with fear, trepidation, and marked restriction of activities regardless of the degree of heart disease. Recently, there has been a pronounced trend toward the liberalization of restrictions, both in the acute and chronic stages. The time-honored treatment of acute myocardial infarction with complete bed rest has been challenged. Current reviews on this subject indicate that the "arm chair" treatment of patients with acute coronary thrombosis does no harm and actually is attended by psychological and physical benefits.^{1 2 3 4 5} It is obvious that rest is a relative term and that confinement to bed is not necessarily synonymous with "rest". Rest means maximum comfort, physical as well as mental, and ceases to be effective when the patient is no longer at ease in his environment. Proponents of this more liberal concept believe that prolonged over-restriction of activity is harmful, is associated with restlessness, and may actually increase physical and emotional effort. The importance of psychological stress in coronary artery disease is receiving considerable attention. When accompanied by an atmosphere of intense concern by the physician and the family, and by too frequent clinical, electrocardiographic, and laboratory examinations, an anxiety neurosis is likely to develop. More recently the study of patients with coronary artery disease by epidemiologic surveys are changing our concepts concerning activity from the long range point of view as well.

It is the purpose of this paper to review the literature and to discuss various aspects of these problems. The literature is extensive. Most interesting are the surveys in recent years by means of epidemiologic techniques which have given pertinent information

relative to the problem. The most thorough survey in this connection has been made by the Social Medicine Research Unit of the Medical Research Council of Great Britain under the direction of Dr. J. N. Morris.^{6 7 8} During 1949 and 1950, approximately 31,000 male employees of the London Transport Executive were carefully studied for occurrence of coronary artery disease. The ages ranged from 35 to 64. The incidence of coronary artery disease in conductors (active) and drivers (sedentary) of double decked buses, of trains and trolley buses, and of the underground railways was observed. Analysis of the data revealed that the benign type of coronary artery disease (in the form of angina pectoris) was relatively more common among the conductors than the drivers, and that the disease appeared at a later age in the conductors. Rapidly fatal coronary thrombosis was more prevalent among the drivers (sedentary); the "immediate" deaths in the drivers was 31 per cent, as against 19 per cent in the conductors. These figures are considered statistically significant, and the natural conclusion to be drawn is that the greater physical activity of the conductors was a cause for their lower incidence and mortality. Further confirmation to suggest that physical activity is important in relation to coronary artery disease was added by a similar two year study of 110,000 men 35 to 59 years of age who were postal workers and civil servants. The results indicated that the incidence of coronary artery disease (morbidity) was lower in the postmen (active) than in the civil servants (sedentary). The case fatality was lower in the postmen (57 of 171) as compared with the sedentary positions (70 of 143); and the early mortality was likewise lower in the physically active group. Additional studies in England and Wales on the total male working population revealed that the coronary mortality of the groups doing physically heavy work was less than half that of the light groups. Similar epidemiologic studies are being carried on in this country by various groups as well as in other foreign countries. The problem is a complicated one, and further studies are clearly indicated

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, Ga., May 1-4, 1955.

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relating not only to the effect of physical activity on coronary circulation but also to the psychological factors, occupational and social factors, nutritional factors (obesity), hormonal and constitutional factors.

The problem of death in relation to exertion in coronary thrombosis has provoked divergent, controversial discussion throughout the years. Review of the literature reveals one group of investigators who believe that coronary occlusion may be precipitated by sudden, exceptionally heavy physical activity such as shoveling snow or the excitement of an athletic contest; the other group believes that coronary thrombosis occurs in the absence of effort, usually at night, and often in the early morning hours, when the blood pressure is low and the coronary blood flow is diminished. Phipps, in his study covering 437 cases of acute coronary occlusion, noted that in 51 per cent of the cases the patient was at rest, in 18 per cent, the patient was undergoing moderate or usual exertion, and only in 13 per cent was excessive physical exercise noted.⁹ In a similar investigation by Master, Dack, and Jaffe including 1,108 cases of acute coronary thrombosis, 52 per cent occurred while the patient was asleep or resting, 21 per cent during routine activity, 16 per cent while walking, nine per cent during "moderate activity", and only two per cent during unusual physical exertion.¹⁰

Although the observations of Phipps, Master, et al, suggest that physical activity is not a precipitating cause of acute coronary occlusion, other workers have reported cases implicating such a causal relationship. French and Dock noted that 35 per cent of 80 fatal attacks of coronary disease occurred within one to several hours after vigorous exercise.¹¹ Fitzhugh and Hamilton reported among 100 cases of acute coronary occlusion that 24 cases occurred during or promptly following some unusual or violent physical exertion and 33 cases occurred after an unusual exertion which was not necessarily violent.¹² Boas reviewed and reported 25 cases of myocardial infarction, 13 of which followed unusual exertion.¹³ Yater et al noted that the proportion of attacks among young soldiers was more than twice as great during strenuous activity as the time spent in such activity.¹⁴ Smith, Sauls, and Ballew reported that 32 out of 53 cases of coronary occlusion were associated with physical exertion.¹⁵

It has been known for some time through pathologic and experimental observations that occlusion of a coronary artery is not invariably followed by myocardial infarction. Moreover, areas of acute myocardial necrosis occur in the absence of a recent coronary occlusion. In a series of 1,000 consecutive autopsies, Friedberg and Horn found that 31 per cent of the cases of acute myocardial infarction were

not associated with a recent coronary occlusion despite meticulous examination of all coronary vessels.¹⁶ The coronary circulation is in a dynamic state of flux, and the degree of myocardial damage depends upon the ability of the coronary vessels to satisfy the demands imposed on the heart. As the atherosclerotic process develops with resultant narrowing of the coronary vessels, a collateral circulation develops, the efficiency of which determines the coronary reserve. If the work load imposed on such a diseased heart creates an oxygen requirement in excess of what the diseased coronary vessels can supply, an attack of angina pectoris, coronary insufficiency, or myocardial infarction may be precipitated. There are varying degrees of coronary insufficiency, and it may be difficult to tell clinically when coronary insufficiency steps over into the zone of myocardial necrosis. The electrocardiogram may be of help, but it is not fool proof or infallible. The electrocardiogram is a device to measure the electrical activity of the heart muscle itself, not the coronary blood flow. It does not measure coronary vessel function. Moreover, myocardial infarction may occur without significant electrocardiographic changes. For these reasons the clinical diagnosis of the degree of coronary insufficiency and myocardial damage is difficult at times.

Assuming the presence of a coronary occlusion, a rational approach to the pathogenesis and to the problem of exertion requires a knowledge of the pathology of coronary atherosclerosis. Briefly, the process consists of thickening of the intimal layer by cellular hyperplasia and fibrosis, the deposition of lipoid and fat, and the formation of capillaries in the subintimal layers. Hyalinization, calcification, and occasional spicules of bone may be formed so that the artery becomes irregularly thickened and rigid. Atheromatous ulcers appear as a result of degeneration and softening of the atheromatous process. The occlusion of an atheromatous coronary vessel may occur in one of three ways: (1) a thrombus superimposed on an arteriosclerotic intimal plaque; (2) a thrombus secondarily resulting from intimal hemorrhage with rupture into the lumen; or (3) an occlusion by intramural hematoma due to intimal hemorrhage. Elevation of the blood pressure in the coronary arteries due to physical or emotional stresses may predispose or precipitate intimal hemorrhage. The swelling induced by the intimal bleeding can be sufficient to block completely the already narrowed arterial lumen, even without the occurrence of thrombosis. Exertion, pain, or emotional excitement may produce not only an elevation of the blood pressure but also an increase in the rate and amplitude of the heart beat adding the element of physical trauma. This leads to intimal hemorrhage and coronary oc-

clusion either by secondary thrombosis or by an intramural hematoma. Exertion, then, may lead to coronary occlusion. On the other hand, to develop primary thrombosis in the presence of effort seems unlikely; the optimum time would be during the night, especially in the early morning hours when the blood pressure is low and the coronary blood flow diminished.

To complicate further this problem, mental exertion or psychosomatic factors are believed now to play not a small part in the pathogenesis of coronary occlusion. It is interesting to note that Selye and Fortier have described increased capillary permeability and hemorrhage, hemoconcentration and hypertension or hypotension (depending on the intensity of the stress) during the alarm reaction "of the general adaptation syndrome."¹⁷ Moreover, significant alterations in hemodynamics and in electrocardiographic tracings have been demonstrated during psychiatric interviews relating to stressful life situations.¹⁸ Emotional and physical stress have been shown to produce an increase in blood viscosity, an increased hemotocrit, a decrease in sedimentation rate, and decreased coagulation and prothrombin times, as well as changes in blood pressure. There is, therefore, objective evidence that the vascular tone and the clotting mechanism of the blood are influenced by physical and emotional factors, involving also the central nervous and endocrine systems. Occlusive coronary artery disease is not due simply to increased atheromata in the coronary vessels. Other conditions are necessary, and the capacity of the heart to deal with these in relation to the demands made upon it is an important consideration.

From the medicolegal point of view, it may be necessary to determine if death were due to exertion, and this poses a very complicated problem. Careful microscopic examination of the heart is imperative. The fact that coronary thrombosis and/or myocardial infarction is discovered at postmortem examination should not be construed as "proof positive" evidence that either lesion was the cause of death. Microscopic examination of such lesions frequently establishes the fact that the thrombus or the infarct, or both, had started to develop hours or days before death occurred, and therefore, could not have been caused by the terminal episode of stress. Clinical records and pathological studies in routine autopsies often reveal multiple coronary thromboses of varying duration without clinical counterparts. Episodes of coronary thrombosis with or without infarction may go unrecognized at the time of their occurrence. A person with such an unrecognized coronary occlusion is prone to unexpected spontaneous death with or without the exertion factor. The surprising feature of such cases is why the person lived as long as

he did rather than why he died. A detailed history should always be obtained if at all possible.

Thus there remain confusion and controversial factors associated with the relationship of stress to death in coronary artery disease. It is a difficult problem. The cause of cardiac death may more simply be divided into two categories: *mechanism* death and *muscle* death (terms introduced by Dr. Herman Hellerstein). *Mechanism* death means any disturbance in the coordinated beat of the heart such as ventricular fibrillation, cardiac arrest, etc. When coronary thrombosis or myocardial infarction is found at the postmortem examination, it is obvious that the same lesion was actually present a short time previously, when the patient was living. A disturbance in the coordinated beat occurred. Had the coordinated beat not been destroyed, the heart would have continued beating. *Muscle* death refers to those cases in which extensive degenerative changes develop in the myocardium; the heart enlarges, and failure occurs.

The effect of stress on the heart is summarized in Figure 1.¹⁹ Note that in the normal heart, a pressor episode does not cause any permanent damage. In the diseased heart with coronary atherosclerosis, however, the pressor reaction may produce coronary insufficiency, or hemorrhage with recovery, transient or persistent evidence of myocardial ischemia, delayed thrombosis, or immediate cardiac arrest. Similarly Figure 2 summarizes how shock, whether post-traumatic or post-operative, may result in thrombotic or non-thrombotic myocardial ischemia and cardiac arrest due to the lowered blood pressure and inadequate flow of blood through the damaged coronary vessels. It should be emphasized that coronary artery disease may go unrecognized until the terminal episode.

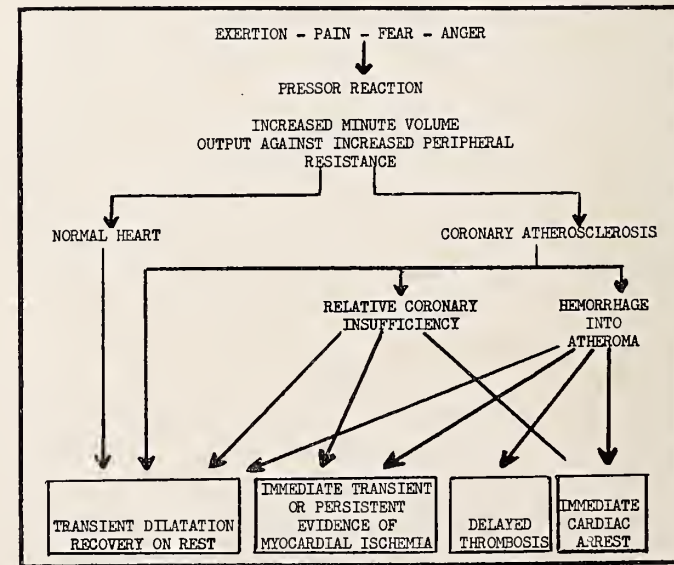


Figure 1
Injuries to the heart from stress.

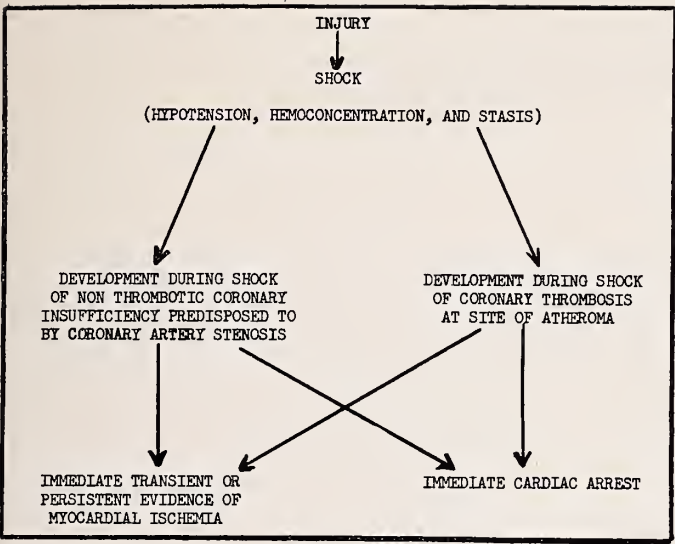


Figure 2

Mechanism by which post-traumatic shock may result in severe myocardial ischemia (infarction or death) in a person whose coronary arteries are the seat of atheromatous change.

The final opinion as to whether stress causes cardiac death rests upon facts that can be obtained only by a good, careful, unprejudiced history, and by a very careful postmortem examination. Each case must be individually evaluated. Exertion may or may not be a factor. Occasionally the claimant in compensation cases may make exaggerated or inaccurate statements which should be diligently investigated. An overindulgent attitude on the part of the physician is also unjust and unethical. To prolong a patient's period of disability and to over emphasize a minimal degree of coronary artery heart disease is to produce a cardiac neurotic. Moreover, to prejudice employers against hiring cardiac patients in industry makes rehabilitation of individuals with heart disease difficult. Extreme care and caution must be exercised in determining the effect of exertion in coronary artery disease. No dogmatic general statements regarding the effect of exertion should

be made. Each case must be evaluated separately.
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New Manual for Doctor Assistants

A new, 500-page textbook or training manual, especially helpful to the girl employed in a physician's office, will be published by W. B. Saunders and Company next January.

The book, tentatively entitled "The Office Assistant—in Medical or Dental Practice," is written by Portia Frederick, Long Beach, Calif., instructor of a two-year course for physicians' aides and laboratory technicians, and Carol Towner of the A.M.A. Public Relations Department.

The illustrated manual is being written to meet an increasing need for training material to equip a girl to handle efficiently both medical assisting and

medical secretarial duties in a physician's office. About 65 per cent of the physicians in the United States today employ only one girl; 23 per cent employ two aides. A physician who hires a nurse often finds her lacking in business skills; if he employs a medical secretary, her shortcomings in the medical-assisting side of her duties are quickly apparent. The trend appears to be toward the emergence of a new career for the girl who works for a physician—that of medical secretary-assistant.

The importance of the medical aide in creating good public relations for her physician-employer is stressed throughout the entire volume.

Medicolegal Investigations

RUSSELL S. FISHER, M.D., Baltimore, Md.

THE RECENT CHANGES in the law governing the investigations of violent, sudden, or suspicious death in Georgia bring to the fore the role of the general practitioner in these investigations. It is he who, in many instances, determines that death has occurred and donates his time to help the legal authorities in their investigation of sudden fatalities. The past 100 years, witnessing the advent of scientific medicine with its chemical and immunological procedures and gross and microscopic pathology, have also made available a great many techniques for use in medicolegal investigations of the cause of death. Paralleling this, the means of committing crimes have also become more intricate. The two developments, scientific medicine and scientific crime, have led, in Europe, to the development of a number of well organized scientific medicolegal investigative departments. This specialty of medicine, however, has been very slow to gain recognition in America, and it is a fact that today only a few of the major cities and seven of the states have laws establishing competent systems for the investigation of sudden, violent, or unexplained death.

The members of the medical profession and the public authorities of Georgia are to be congratulated on the strides you have made in the past two years. For the first time, all of the knowledge and specialized facilities of medicine can be brought to bear in protecting the public by the investigation of those deaths in which the public interest is involved. Elsewhere, as here, until two years ago, these investigations were carried out by lay coroners or Justices of the Peace who are frequently forbidden by law, or restricted by inadequate budgets, to have performed the investigations and the autopsies necessary if all of the important facts concerning the cause of death are to be learned. The interest of each of your citizens demands more than simply the solution of the cold-blooded murders. It is as much a fallacy to believe that a layman could view a dead body and determine the cause of death in a fashion adequate for criminal court prosecution, compensation court awards in proportion to the role of occupational factors in a death, or the health authorities' need for

prompt and accurate diagnosis as to the cause of death in persons succumbing to contagious disease if epidemics are to be prevented, as it would be to assume that the first man one meets on the street could examine your youngster's painful stomach and decide if an operation for appendicitis is needed. A rebuttal of this statement has been offered that the lay coroner can and does acquire help from physicians when an autopsy is needed. The error in this reasoning becomes obvious when one realizes that the primary and important decision as to the necessity of performance of an autopsy must usually be made on the basis of external physical findings, a carefully elicited medical history, and a knowledge of the disease process which the lay coroner obviously does not possess. Medical examiners all over the country have pointed out that cases are frequently seen where, despite the absence of external injury on the body or circumstances to support "reasonably grounded suspicion of crime," an autopsy performed because the cause of death is not accurately known, reveals evidence of homicide, suicide, or accidental death. This requires a high index of suspicion, not necessarily of crime, but of the existence of concealed violence if you are to accomplish, in the best fashion, your role in aiding the ultimate attainment of justice. Too, the medical schools must rise to the occasion and teach these disciplines both to the practicing physician and to their students if they are to fulfill their duties to the community.

Definition of Medicolegal Cases

What then are the most common problems that confront the general practitioner-medical examiner who is cooperating in the investigation of medicolegal cases? First, a definition of medicolegal cases. Your Legislature has prescribed wisely in defining them—"when any person shall die as a result of suicide or casualty or suddenly when in apparent health or when unattended by a physician, or within 24 hours after admission to a hospital without having regained consciousness, or in any suspicious or unusual manner, or when a person dies suddenly without attending physician, or when, upon proper affidavit, it is ordered by a court having criminal jurisdiction." This does not necessarily mean that an autopsy is necessary in every medicolegal case, but it must be the general formula that the cause of death must be demonstrated beyond reasonable doubt in

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, Ga., May 1-5, 1955.

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all deaths falling in any of the above categories. To compromise this philosophy is to invite failure of detection of murder or the destruction of evidence in murder cases to such an extent that the case cannot be successfully prosecuted. The courts are supported at considerable public expense to administer justice and to settle disputes in the most informed manner possible. They need the medical facts which you can obtain many times only through an investigation and post mortem examination performed on official order at the time of death. Experience has shown that between 15 and 20 per cent of all deaths will require official inquiry to satisfy these criteria.

Recording of the Facts

Second only to selection of cases is the importance in medicolegal problems of preserving the evidence once it is developed. The necessity of writing adequate notes at the time the case is being done, of sketches of the nature and sites of injuries, with description in such detail you will be able to describe with assurance and accuracy months later in court, cannot be overemphasized. I recall a recent experience in which a post mortem examination was performed by a competent pathologist, and he no doubt witnessed the linear fracture in the left temporal region of a child who had been beaten by his father. The fracture had been demonstrated by X-ray before the infant's death. He was busy and performed several other autopsies before dictating the record. He described the subdural hematoma but somehow left out the important details of the fracture. The defense attorney made short work of his testimony when he made him admit that he did not describe the fracture and was confused as to whether it was actually present since it did not appear in his record. It is well to emphasize, at this point, the usefulness of going over your report in detail, correlating it with photographs and other information as to the pathogenesis of the injuries just before you go to court to testify, as well as while the case is still fresh in your memory. It would be remiss to point out the deficiencies of the pathologist in this regard without also emphasizing an even earlier step in the investigation; namely the examination of the body and the clothing and the obtaining of all data possible before the autopsy is begun. The nature of our work is such that we cannot do every possible determination in every case. The choice of procedures to be used is greatly dependent on the facts available before the autopsy is started, and you are well within your rights in demanding that the police and other officials make every known fact available to you at the time you first look at the body.

Characteristics of Gunshot Wound

To examine the nature of the pathological evidence in a variety of deaths it may be useful to begin

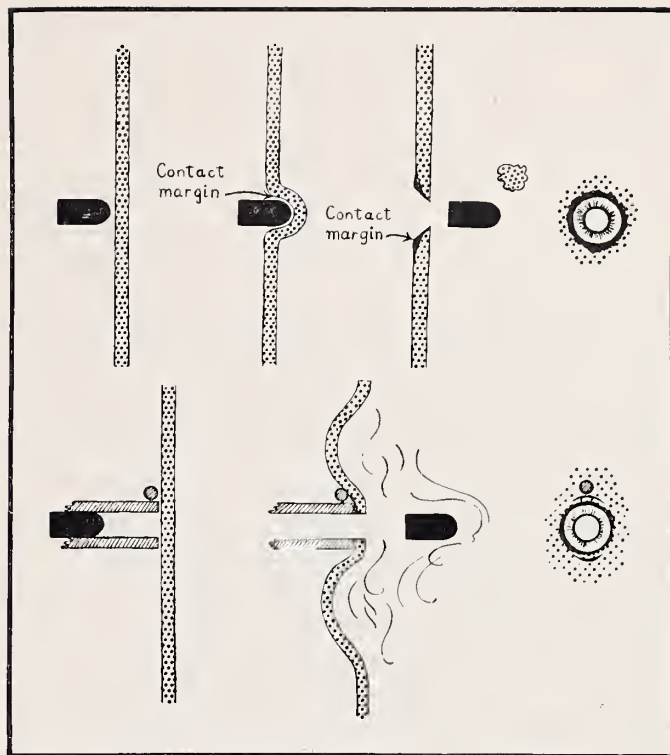


Figure 1

Mechanism of skin wounding by bullet.

Above—Marginal abrasion in distance wounding.

Below—Annular contusion and sight marks in close contact wounding.

with a review of some important criteria for evaluating gunshot wounds which are the most common cause of homicidal and suicidal death in our jurisdiction. The autopsy may shed additional light on the findings at the preliminary examination, but the general practitioner should have sufficient knowledge of the matter of gunshot wounding to allow him to estimate the range in most cases. These characteristics are—(1) marginal abrasion and soiling—the denudation of the surface epithelium around the entrance wound where the skin was depressed and stretched over the entering bullet. This causes soiling and scraping away of the margins in closest contact with the bullet and usually leads to a hole slightly smaller than the caliber of the bullet. It is the distinguishing characteristic of bullet entrance and is seen at all ranges. (Figure 1) (2) Stippling or tattooing or powder soiling in non-contact, close range wounds. This is due to the impact against the skin of hot powder grains from the gaseous discharge and is made up of multiple tiny abraded and burned areas in a circle surrounding the bullet defect. The density of the stippling and soiling by smoke varies inversely with the distance of fire and the diameter varies directly with the range; i.e., the closer the muzzle, the smaller but the more dense is the circle of stippling and soiling. In general, tattooing indicates the range to be under 15-18 inches although exceptions have been noted with large caliber weapons. The experi-

mental firing of the same gun with the same ammunition may allow the weapons expert to produce similar patterns to those on the victim and hence to estimate the range of fire within a reliability of one or two inches. Here the need for scale photographs of the wounds is self evident. (3) Annular abrasion or contusion. This term is applied to an arc or circle or other marks of abrasion or contusion separated from the edge of the defect with its marginal abrasion by a narrow band of intact skin but related to the wound and caused by the sight or other points on the end of the muzzle. In the case of arcs of abraded skin, they will be concentric with the bullet hole. The lesions are caused by sudden slapping of the skin against the end of the gun muzzle as the skin is blown back by gases expanding beneath it. In general the point of contact will be the outer margin of the muzzle, and frequently there will be "sight marks" where the skin was blown against the foresight or the recoil mechanism on the end of the gun barrel. When present, the annular contusions and "sight marks" are unmistakable evidence of close wounding by gunshot. They may be obscured sometimes by the lacerations caused as the skin is torn by explosive escape of gases from powder discharge. (4) Foreign bodies in the wound. In close range or contact wounds it is common to find fragments of burned or unburned powder or wadding along the tract of the internal wound. The use of the dissecting microscope in this study is advised. In connection with the soiling by powder residue, mention may be made of the use of the paraffin cast and diphenylamine test for powder residue on the hands of persons suspected of firing a gun. Studies in the F.B.I. laboratories have shown that false positive nitrate tests can be obtained with smokers, and positive tests are not therefore conclusive evidence that the suspect did, in fact, fire a revolver. Automatics, of course, rarely have powder escape from around the base of the barrel, and the test would be of extremely doubtful value in automatic weapon cases. There are, however, some cases when the presence of multiple nitrate particles distributed over the approximating margins of the thumb and first finger and the backs of the first, second, and third fingers are of some usefulness in evaluating a case. This is particularly true if they are used as a demonstration to the accused, and he, already having knowledge that he fired the gun, is impressed by the positive test to the extent that he may be more cooperative in making a statement.

Blunt Injuries

In the case of blunt injuries, two significant points should be made. Of foremost importance is the recognition that intracranial, subdural, and even extradural hemorrhages and intrathoracic and abdominal

hemorrhages from lacerated viscera can and frequently do occur without there being the slightest evidence on the surface of the body that trauma has been sustained. A second point to be mentioned is the importance of attempting to determine the direction of the force causing lacerated injuries to the surface of the body at the time of the first examination of the wound. This is frequently possible because of the tendency of wounds to show undermining on the side to which the force was directed. Such a simple observation as the fact that the upper margin or the lower margin of a horizontal laceration on the back of a head shows undermining may be enough to point out the difference between a homicidal assault with a blow from above and behind or a fall wherein the victim's head struck the curb as he fell backwards. That subdural hemorrhages and skull fractures can be an artifact caused by overheating of the cranial content during a conflagration is an important consideration in evaluating head injuries in bodies removed from burned buildings.

Incised Wounds

In incised wounds the physician should study the margin of the wound for the evidence of hesitation marks typical of self-inflicted wounds in contrast to the sharp clean margins usually caused by an assailant. Likewise, the pathologist, by estimating the depth of penetration of the instrument as well as its diameter or minimum width, may render real assistance to the police in their search for the weapon.

Criminal Assault

The medicolegal investigation of rape cases is frequently a duty of the family physician because he is apt to be the first person called when the victim seeks aid or advice. His role should include both the care of the patient and the collection of the evidence likely to be useful to the law in establishing the occurrence of a sexual assault and the identity or guilt of the assailant. To sustain a criminal assault case, the courts usually require evidence that the crime was accomplished by violence and against resistance of the victim as evidenced by bruises, scratches, or other injuries on the body of the woman as well as the evidence of semen and injuries in and about the genitalia of the victim. The identification of spermatozoa in stained smears from the victim's vagina is the best proof of intercourse and, if accompanied by evidences of injury, may confirm the allegation of rape. Any delay in collecting such specimens may defeat the purpose of the examination. They should be collected on cotton swabs and smeared immediately to glass slides which are allowed to dry promptly. Wet swabs deteriorate and a specimen should never be submitted to the laboratory in this fashion. Positive identification of spermatozoa in smears from Egyptian mummy material have been obtained where

the material was dried. Yet, spermatozoa may disappear in as little as an hour from the normally moist acid vagina. Specimens of clothing bearing stains should be allowed to dry before a fan or a warm radiator and then be packed loosely for transmission to the laboratory. In certain cases, a liquid specimen may be aspirated from the vagina for the phosphatase test. These samples should be refrigerated continuously until the testing is done. There is no phase of medicolegal investigation in which promptness and the proper kind of sample is of greater importance if success is to be achieved than in the collection of evidence in rape cases.

Determination of Alcohol Content

The determination of the alcohol content of the victims of violent deaths is another aspect of medical evidence collection, the importance of which is not widely recognized. Yet we find alcoholism to be common to a greater percentage of our vehicular and homicidal deaths than almost any other factor. The general practitioner who is investigating such cases cannot consider his investigation complete without collection of a sample of blood or spinal fluid for the alcohol determination. Tables I and II present some

Table I
Alcoholism in Highway Victims
1950-53 Baltimore

Type of Accident	Total Cases	Below .04%	0.05%—0.15%	0.15%+
Pedestrians	177	94	22	61
Drivers	105	49	24	32
Passengers	102	70	13	19
Total	384	213	59	112

Table II
Alcoholism in Victims of Homicide
1950-53 Baltimore

Manner	Total Cases	Alcohol None	Concentration .01-.14	Percentage .15-.25	.25+
Shooting	126	55	24	28	19
Stabbing	108	30	11	29	38
Blunt Force	31	12	94	13	2
Total	265	97	129	70	59

statistics on the frequency of alcoholism in our medicolegal cases.

Summary

1. The public interest demands that our laws provide and the administrative agencies in our government establish the facilities for competent investigation of all deaths due to violence, of accidental nature, or suddenly when in apparent health, or under unusual or suspicious circumstances.
2. In many urban and nearly all rural areas of the country, it is the general practitioner who will be called on to conduct the primary investigation, elicit medical history, and make the decision as to the necessity of an autopsy. He is a most important member of the medicolegal investigative team.
3. The general practitioner, who would assist in the medicolegal investigations, should familiarize himself with the basic pathology of the various mechanisms of wounding and the fundamentals of collection and preservation of evidence.
4. Alcoholism is an important contributing factor in many of our violent deaths and the necessity of toxicologic study is again emphasized.

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Journal Editor Is Married



Dr. and Mrs. Edgar Woody, Jr.

ON AUGUST 27, 1955, Miss Susan Redfield, daughter of Mr. and Mrs. Scranton H. Redfield of Atlanta, was married at St. Luke's Episcopal Church, Atlanta, to Edgar Woody, Jr., Editor of the *Journal of the Medical Association of Georgia*. Dr. and Mrs. Woody will be at home in the Paces Ferry Tower Apartments, 374 East Paces Ferry Road, Atlanta, after the 6th of September.

(Note: Journal editors don't get married everyday; in fact, so far as we can determine, this is the first time that one has gotten married while he was editor. Therefore, the Publications Committee has directed that this important event be recorded for posterity; this is done without the knowledge or consent of the editor or his wife. David Henry Poer, Chairman of the Publications Committee.)

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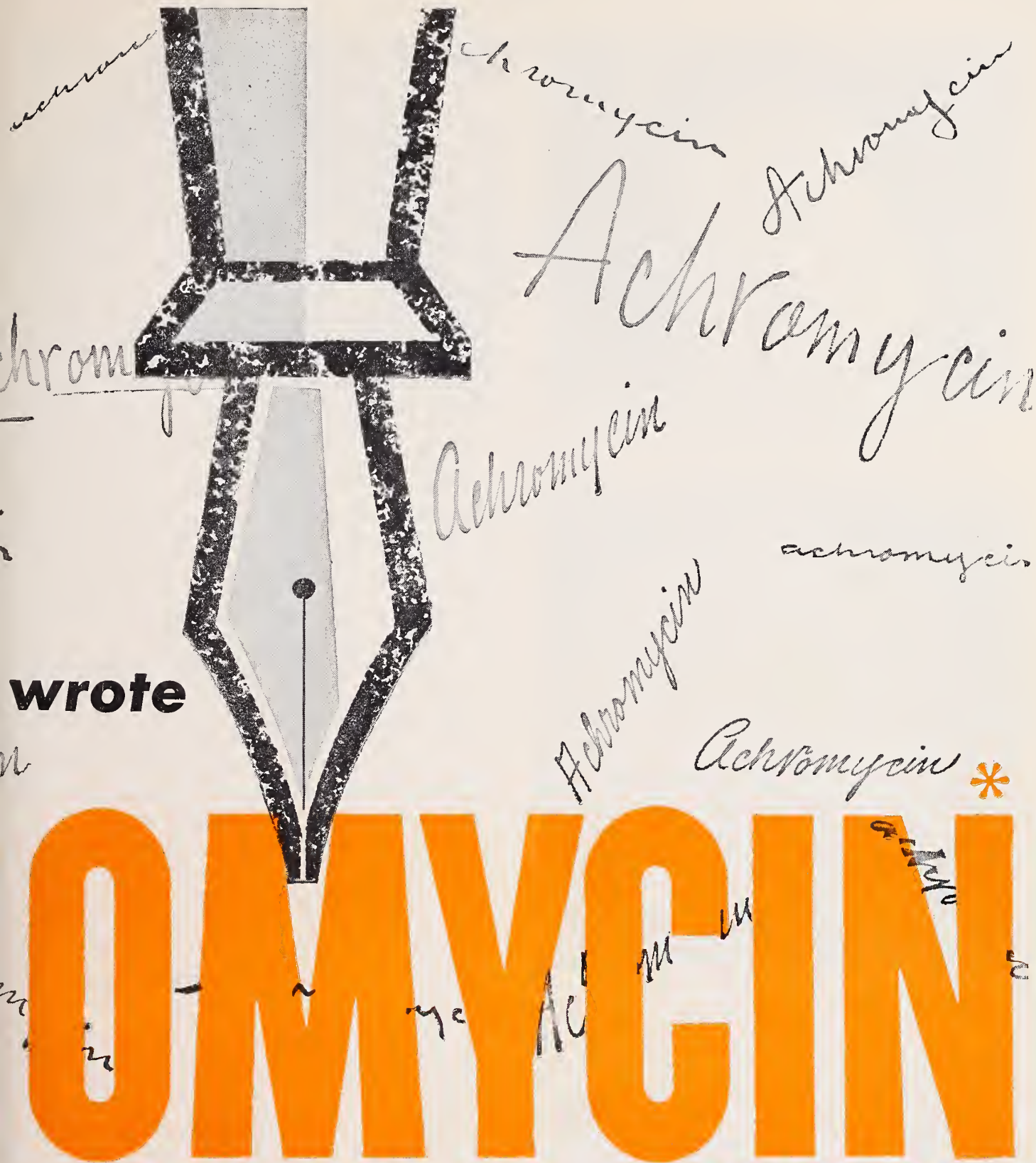
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Malignant Mesenchymal Tumor Simulating Liposarcoma Originating in the Mediastinum

A. WORTH HOBBY, M.D., Atlanta, Ga.

THE RARITY OF LIPOSARCOMA is evidenced by the report of 200 cases of Kozonis,¹ et al., up to 1949. Kozonis states that the English literature lists only four cases originating in the mediastinum. Storey and Kneutson² reviewed the literature in 1951, finding the same cases^{3 4 5 6 7 8} except the case of Narr and Wells⁸ is omitted and the case of Barbier and Millard⁷ and Lennert⁶ (not in English) is added.

Liposarcoma usually is a single tumor, but it may be multiple. It may occur at any age, but it is usually found in middle life and affects both sexes equally. Richman⁹ reports liposarcoma found in his study of congenital malignant tumors in the newborn.

Very slow growth in an asymptomatic patient is characteristic of liposarcoma. Pressure or hemorrhage may suddenly cause symptoms accompanied by very rapid growth. Kozonis¹ states that it is estimated the average duration of symptoms is 10 years from the first complaint until metastases are known. Metastasis is always a late manifestation and has a predilection for the central nervous system, lungs, and liver.

According to a survey of the literature, the usual site of origin is superficial. Stout,¹⁰ Moreland and McNamara,¹¹ and Jones¹² list the legs, thigh, gluteal region, popliteal space, trunk, head, neck, and arms. Holden¹³ and Hirsch¹⁴ report retroperitoneal origins, while McCartney and Wynne¹⁵ and Tesler¹⁶ report peritoneal locations. Intra-abdominal liposarcoma is reported by Benedict.¹⁷ A number of writers^{18 19 20 21 22} describe bone as the origin, while Caldwell²³ reports the meninges as the site of origin. Other sites of origin are spermatic cord,¹⁰ breast,^{24 25} vulva,²⁶ and common bile duct.¹⁰ Brady and Wayburn²⁷ stress the association of tuberous sclerosis of brain and dermatological lesions of the face (known as adenoma sebaceum) with liposarcoma of the kidney.

Although histologically recognized by Virchow²⁸ in 1857, the classification has been revised often. Three general types of liposarcoma are mentioned by Caldwell and Zininger:²³ (1) lipomyxosarcoma, a liposarcoma which has undergone myxomatous degeneration; (2) lipoma with sarcomatous degeneration, the tumor arising from fibrous tissue stroma; and (3) liposarcoma, arising from fatty tissue and tending to become encapsulated, but they extend by continuity of tissue and/or metastasize. Ewing²⁹ divided liposarcoma into two main types: myxoliposarcoma and the granular cell lipoblastoma. Stout³⁰ divided liposarcoma into four groups: (1) well-differentiated myxoid type, (2) poorly differentiated myxoid type, (3) round-cell or adenoid type, and (4) mixed types. These types tend to recur when removed. Radiosensitivity of these tumors is a debatable question among radiologists.

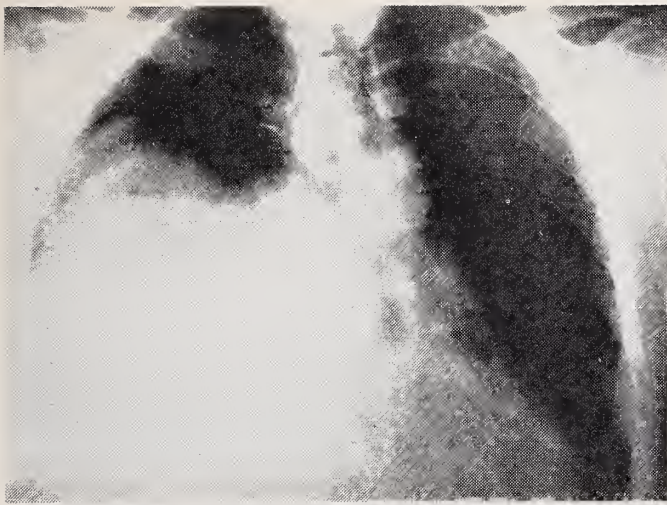
The mediastinum is a relatively small area to be associated with so many vital structures. Approximately 25 per cent of primary mediastinal tumors are malignant. Tumors within the thoracic cage often originate in the mediastinum or invade it if not removed early. The most common malignant tumors of the mediastinum are lymphoblastoma and lymphosarcoma. Unusual clinical manifestations and atypical radiological pictures make the diagnosis difficult. Space will permit only the suggestion of the use of bronchoscopic examination and tomograms combined with roentgenograms of lungs and esophagus. Pneumothorax should be used more often than it appears in the literature as a diagnostic procedure.

Case Report

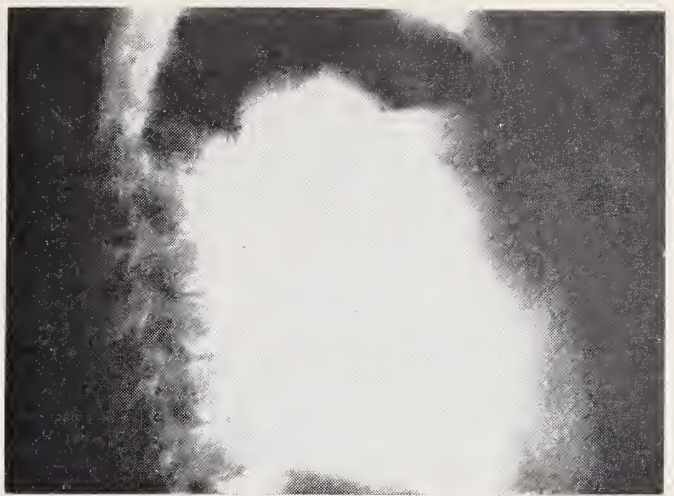
This is a follow-up with autopsy findings of a case reported in May 1948 before the American College of Chest Physicians in Chicago.

A 58-year-old white woman was first seen in the office on November 22, 1947. She stated that she had been well until October 15, 1947. Her chief complaint was extreme dyspnea accompanied by a rasping non-productive cough beginning four weeks previously. On assuming a prone position the dyspnea increased, and frequently acute pain was present throughout the right chest with severe pressure substernally. She had lost 10 pounds in the two previous months and had occasional episodes of nausea without vomiting. Her feet and ankles were swollen at the end of workday, but they returned to normal by the following morning.

Presented before the Staff Meeting of the Piedmont Hospital, June 14, 1954.



Roentgenogram (posterior-anterior), dated December 10, 1947, showing lobulation in right chest of large tumor which was removed January 12, 1948.



Right lateral roentgenogram of chest, dated December 10, 1947, showing lobulation of large tumor removed January 12, 1948.

Her past history was non-contributory.

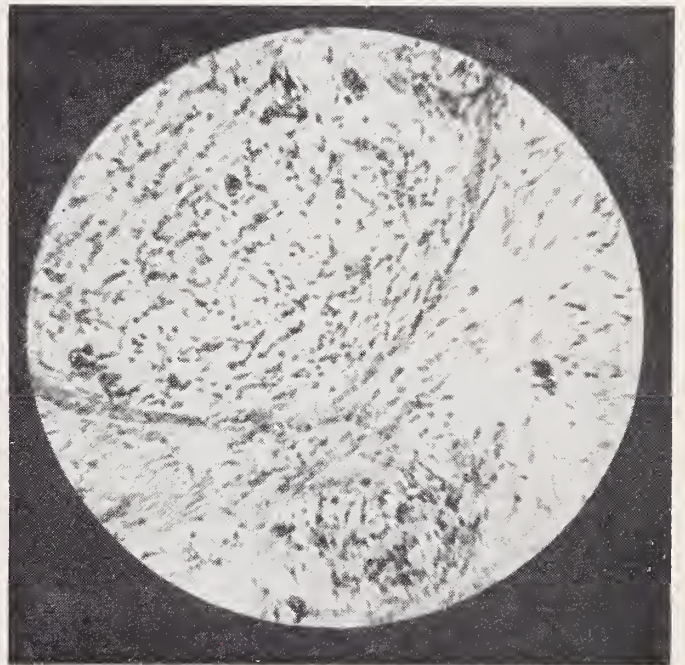
Physical examination revealed a white female who appeared older than the stated age. Her history was interrupted continuously by paroxysmal coughing and gasping. Her voice had a peculiar brassy tone. The veins of neck did not appear distended, and no cyanosis was present. The trachea was in the midline and showed no tug. No lymphadenopathy was present. The heart sounds were distant, and the heart was slightly displaced to the left. The pulse in both upper extremities was equal but rapid (100 per minute). The blood pressure was equal in both arms, 158/100 mm. Hg. Both ankles showed a slight pitting edema.

Auscultation over the lungs revealed no breath sounds on the right and only a few moist rales in the left posterior base. Percussion revealed only flatness over the right lung and slight shifting of the heart to the left.

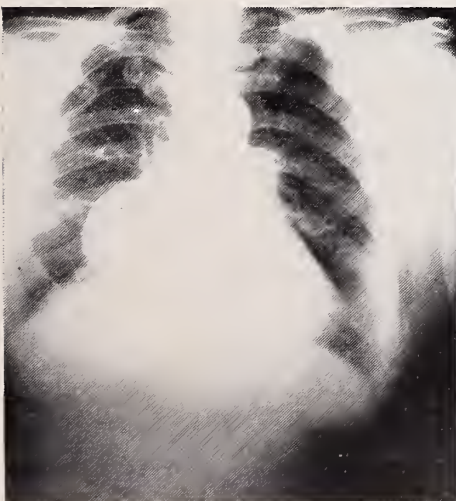
Fluoroscopy revealed complete opacity throughout the right chest. Roentgenograms of the chest confirmed the fluoroscopic findings, but gave the impression of lobulated areas of increased density in the right apex.

Laboratory studies were within normal limits.

Thoracentesis revealed a small amount of bloody fluid containing no malignant cells on examination. Operative procedure was advised. The patient wanted to go to her home town for surgery. She was referred to Dr. Alton Ochsner in New Orleans. He removed a tumor weighing 2,950 grams from the right chest on January 12, 1948. Its main effect had been compression. It arose from the mediastinum and extended between the upper and middle lobes of the right lung, adhering to both. Her recovery was uneventful. The pathological report revealed



Microscopic view of section of tumor removed January 1948.



Roentgenogram of chest, dated August 23, 1949, showing second recurrence of tumor which was removed August 29, 1949.



Roentgenogram, dated January 30, 1951, showing third recurrence of tumor, almost filling right thoracic cage, which was again removed February 12, 1951.



Roentgenogram, dated March 1, 1954, showing the right thoracic cage filled with tumor mass just prior to death.

a liposarcoma arising from the mediastinum.

She was again seen in the office on April 18, 1949, with the chief complaint of general malaise, poor appetite, cough and wheezing on deep breathing. Dyspnea was again experienced in the prone position. Roentgenograms of the chest showed a return of her previous pathology to a lesser extent and confined to the mediastinum. Again she was sent to Dr. Ochsner for surgery, and on August 29, 1949, a mass six cm. in diameter was removed from the anterior mediastinum which was densely adherent to the middle lobe. Another mass was removed from the lower anterior mediastinum which had adhered to the inferior lobe. Recovery was uneventful.

When this patient was seen for the third time on January 30, 1951, two-thirds of the right chest was occupied by a large mass. On February 12, 1951, pneumonectomy was done because of involvement of all lobes. Nothing more was heard of the patient until March 1, 1954, when roentgenograms showed complete opacity of the right chest. She was admitted to Foundation Hospital on March 6, 1954, and died on March 14, 1954. A course of nitrogen mustard therapy was begun in the hope that sufficient palliation could be obtained to further resect the tumor mass. The tumor was compressing the left lung to such an extent that the only hope of relief was removal of at least part of the mass. She failed to respond. This was six years and four months after the patient was seen the first time.

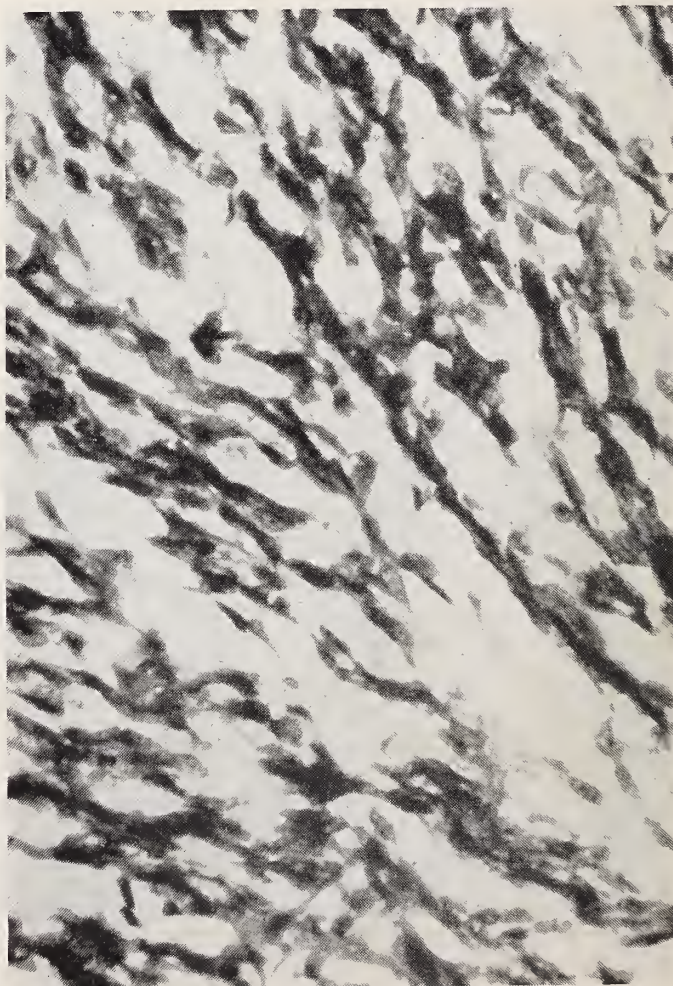
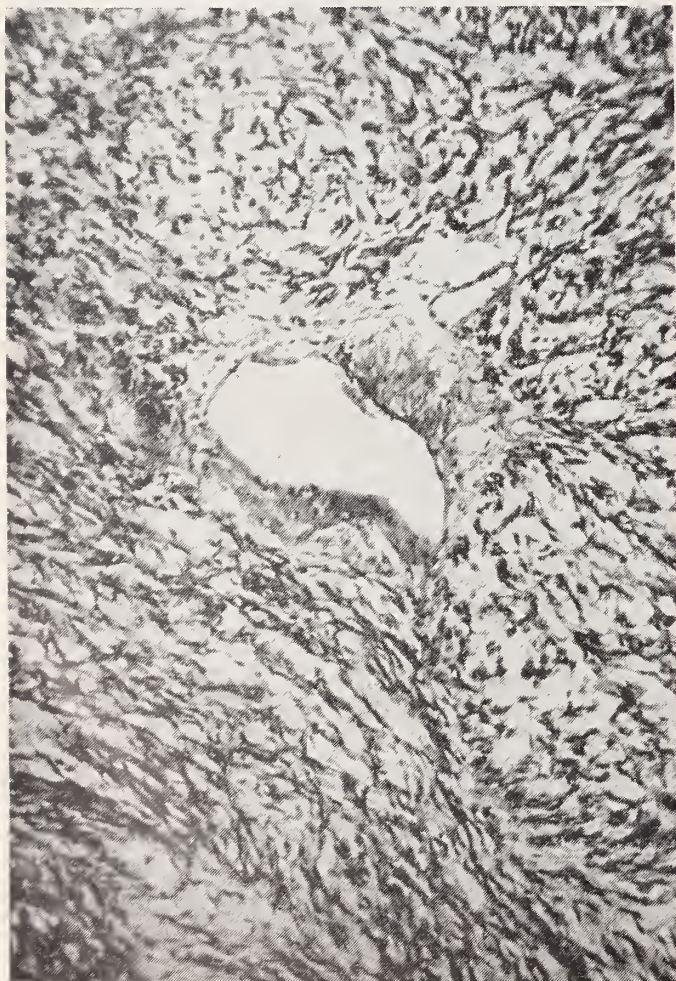
Autopsy Reports The body showed little except marked emaciation. On entering the chest cavity it was found that the right hemithorax was completely filled with a large tumor which was of firm, rubbery consistency and varied in color from slightly pink to yellow to white. Scattered throughout the tumor were patchy areas of liquefaction which obviously were due to necrosis. The tumor apparently originated in the mediastinum and had now grown so as to compress the trachea and shift it to a position well to the left of the midline. The tumor invaded also the left pleural cavity, and it compressed the left lung posteriorly and laterally so that the left lung occupied only about one-fifth to one-fourth of the left chest cavity. There was approximately 100 cc.'s of serosanguineous fluid in the left pleural cavity and about 200 cc.'s of clear fluid in the right cavity. Complete exam-



Photograph of tumor, weighing 2,950 grams, removed January 12, 1948.

ination of the entire body failed to disclose any evidence of distant metastasis.

The microscopic diagnosis of liposarcoma had been continued throughout her six years of illness. However, the microscopic



Microscopic view of section of tumor found at autopsy, March 1954.

examination of tissue removed at autopsy was examined by pathologists in three different locations with complete disagreement as to diagnosis. The slides of the tumor first removed in January 1948 were reviewed. The autopsy report carried a diagnosis of recurrent thymoma.

These slides and new slides made from tissue removed at autopsy were examined by a pathologist in Atlanta, resulting in a diagnosis of fibrosarcoma.

The following is a quotation (with permission) from the Armed Forces Institute of Pathology, Washington, D. C., of the same slides and new slides made for tissue from autopsy and dated 7 January 1955:

"Slides prepared from formalin fixed tissue were stained with hematoxylin and eosin, oil red O, phosphotungstic acid hematoxylin, iron hematoxylin and a reticulum stain. In the H&E stained slides some finely vacuolated cells were seen, and the ORO preparation revealed lipid droplets in a considerable number of tumor cells. These findings were considered suggestive, but in themselves not diagnostic of liposarcoma. Longitudinal fibrils and a suggestion of cross striations were seen in some tumor cells in the H&E stained slides and somewhat better in the PTAH and iron hematoxylin stained slides. These features suggested to the staff the possibility of rhabdomyosarcoma with which the histopathology is not incompatible. Another possibility considered on the basis of the above findings was a mixed mesodermal tumor (malignant mesenchymoma) with myosarcomatous and liposarcomatous elements. Neurogenic sarcoma was considered to be a remote possibility."

Discussion

Geschickter³¹ adequately describes the variable microscopic appearance of these tumors. Falciform sarcoma with compact spindle cells or numerous immense giant cells with degenerating nuclei and a large amount of foamy cytoplasm, form most of the malignant tissue. Myxomatous stroma with embryonic fat and adult fat form islands and surround the malignant elements. The picture varies greatly.

This case varies from the one reported by Kozonis¹ et al., in that the symptomatology does not involve the vascular system and the tumor occupied the thorax causing compression with multiple recurrence. It is hard to conceive of such large tumors existing without more symptoms. Therefore, each time the patient presented advanced pathology and little symptomatology. Deep roentgen-ray therapy would have been used if she had returned before the masses became so large. Treatment of liposarcoma consists of excision early and as completely as possible. Deep roentgen therapy depends on the feeling of those taking care of the case.

The prognosis is poor in terms of survival, but the end may be delayed for years provided the patient has early complete excision and returns for frequent examinations regardless of symptomatology.

A study of the pathological reports indicates that this is a malignant mesenchymal tumor which is as rare as a pure liposarcoma. This case shows also that some areas of the tumor mass may resemble one type and other areas may lead to an entirely different diagnosis.

Summary

Mediastinal liposarcomas and malignant mesenchymal tumors are rare enough to warrant reporting. This case survived six years and four months after first seeking treatment. The symptoms were caused

primarily by pressure on surrounding parts. This and previously reported cases serve to keep us constantly aware of the danger of all mediastinal masses. With this in mind, frequent roentgenograms of the chest become a must in examination of patients.

478 Peachtree Street, N. E.

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Familial Polyposis of the Colon

WILLIAM G. WHITAKER, M.D., and JOHN E. SKANDALAKIS, M.D., Atlanta, Ga.

FAMILIAL POLYPOSIS of the colon is a distinct genetic and clinical entity manifested by growth of numerous adenomatous polyps from the rectal and colonic mucosa. It is transmitted by both sexes through several generations. Considerable confusion regarding its terminology has existed in the literature. Many of the terms describing this disease utilize the word *congenital*, which in effect is a misnomer, since no cases have been reported which demonstrated the presence of a polyp at birth.

Several theories have been proposed suggesting that gene mutations appearing in succeeding generations may explain the familial aspects of this disease. If the gene is dominant, familial polyposis of the colon may appear in each succeeding generation, both in male and female. If it is recessive, the disease will be produced only if both parents have the recessive gene.³ The actual onset or the appearance of polyps may be the result of some type of genetic change in an apparently normal growing mucosal cell. The inevitable development of malignancy in familial polyposis is poorly understood; perhaps it is another manifestation of gene mutations.

Menzel, in 1721, first described a case of diffuse polyposis of the colon in a boy of 15 years.⁴ Many authors subsequently reported isolated instances of this disease, and, in 1890, Handford reported the first case of familial polyposis of the colon with the development of cancer of the bowel.² This patient was a 34-year old woman who died of cancer of the rectum.

Familial polyposis of the colon is primarily a disease of youth and early middle-age. It has been estimated that diagnosis is usually made at the average age of 19 or 20. It is known that the polypi usually appear between puberty and the age of 30. It appears to be more common in men than in women. The symptoms of familial polyposis of the colon may be absent for a long period after the actual demonstration of polypi. The first and usually the most constant symptom is diarrhea, the loose stools often containing blood and mucus. Many patients will note the actual passage of polypi of various sizes. Secondary anemia usually is noted as a result of the constant small daily blood losses. Intestinal obstruction and intussusception due to large polyps have been reported. The polyps usually appear everywhere in the

colon, but there is a tendency for the greater concentration to be in the area of the rectum and the sigmoid colon. The number of polyps will vary from a few to several hundred, depending on the patient's age and the area of colon involved. They appear to be sessile or pedunculated, and many show ulceration and hemorrhage. They vary in size from a few millimeters to masses as large as 10 cm. or more in diameter. They range in color from pale pink to deep red. The actual bulk of the polyps gives the colon an increase in its total weight. Microscopically, the polyp is characterized by a stalk-like, connective tissue base surrounded by relatively normal appearing epithelium. A typical hyperplasia is quite commonly present in the polypoid lesions, particularly in those which have given rise to clinical symptoms. Obviously, in those having undergone malignant degeneration, the cells become more atypical and invade into the deeper layers of the connective tissue toward the center of the polyp.

The potential incidence of cancer resulting from this disease is estimated to be 100 per cent. Ultimate malignant degeneration is said to be a constant characteristic of familial polyposis of the colon. Cases have been reported of patients as young as 12 years with malignant degeneration in numerous polyps. It has been suggested by Schaffer that nearly all patients with familial polyposis who are now alive, and are well without malignancy, are usually under 30 years of age.⁵

The diagnosis of familial polyposis is made from the patient's history of the family trait of carcinoma of the colon, and by digital examination where one feels multiple polyps of various sizes. Sigmoidoscopic examination will usually substantiate the diagnosis. Roentgenologic examination utilizing barium enema with double contrast studies is particularly effective in visualizing barium coated polyps throughout the colon. This disease should be differentiated from true multiple adenoma, polyps found in association with hyperplastic tuberculosis, polyps found in association with old strictures of the colon, and polypoid conditions of the mucosa which result from chronic ulcerative colitis.

The treatment of familial polyposis of the colon is surgical, and consists of removal of the affected tissues. Medical and x-ray therapy are to be men-

tioned only in so far as temporary symptomatic treatment is concerned. The two principal methods of surgical treatment are: (1) total colectomy with abdominoperineal resection of the rectum and performance of a permanent ileostomy, and (2) total colectomy and ileorectostomy with eventual fulguration of the existing polyps in the remaining rectum. The choice of the procedure will depend on several factors. Case reports have demonstrated cancer arising in the rectal stump following colectomy and ileorectostomy. These reports have suggested to some surgeons that total colectomy with abdominoperineal resection of the rectum should be employed in all instances. Other surgeons have utilized ileorectostomy; they have been careful to obliterate the polyps remaining in the rectal pouch and to repeat this procedure from time to time with direct visualization of the rectal mucosa by means of the proctoscope. If one is to employ ileorectostomy, it is essential that there be no evidence of carcinoma in the rectum and that the cooperation of the patient be secured, so that adequate follow-up and adequate fulguration of existing and recurring polyps may be carried out.

Case Report

J. H., age 18, had been well until early in 1953, one and one-half years ago, when he first noticed weakness and frequent loose stools, often containing blood, and several times the actual passage of small round polyps. A rather constant symptom was a dull pain in the lumbar area. There had been no weight loss.

His past history was essentially negative. His family history was interesting in that his father had recently died of carcinoma of the colon. Further investigation of his family history was positive for familial polyposis throughout four generations (Figure 1). Diagnosis was established by digital rectal examination, by sigmoidoscopic, and by contrast barium studies of the colon; and it substantiated by the strong familial tendency of his family toward ultimate carcinoma of the colon. This patient was subjected to total colectomy with ileorectostomy, following the usual bowel preparation utilizing Sulfathalidine® and Neomycin® sulfate. The abdomen was entered through a left paramedian incision. The left colon was completely mobilized and the splenic flexure was freed. Following this, the right colon was mobilized, and the terminal ileum was transected approximately six inches from the ileocecal valve. The lower sigmoid and the rectum were mobilized, and the rectum was transected approximately five cm. below the pelvic peritoneal reflection. All polyps in the upper three cm. of the remaining rectum were fulgurated under direct vision before the ileorectal anastomosis was accomplished. An end-to-end ileorectostomy was performed using interrupted silk sutures in two layers. Following completion of this anastomosis, the entire colon was removed. The resected colon contained approximately 350 polyps with the greater density being noted in the rectum and the sigmoid areas. The average size of the polyps was approximately five mm. in diameter. One polyp was noted in the appendix, and a three cm. polyp was noted in the splenic flexure. Careful histologic studies of these polyps failed to reveal any evidence of malignant change.

His postoperative course was uneventful, and at no time did he suffer serious electrolyte disturbances. He was fed as early as the third day, and by the fifth day was taking a full diet, supplemented by liberal servings of salted peanuts. On the tenth postoperative day, he was dismissed from the hospital. At this time, he was having from two to four semi-solid stools daily, which were fewer stools than noted upon entering the hospital. Approximately two months after colectomy, the patient was readmitted to the hospital and under saddle-block anesthesia, approximately 45 polyps of varying sizes were removed from the rectal stump by electrocoagulation. The actual site of the anastomosis as seen through the proctoscope was noted to be

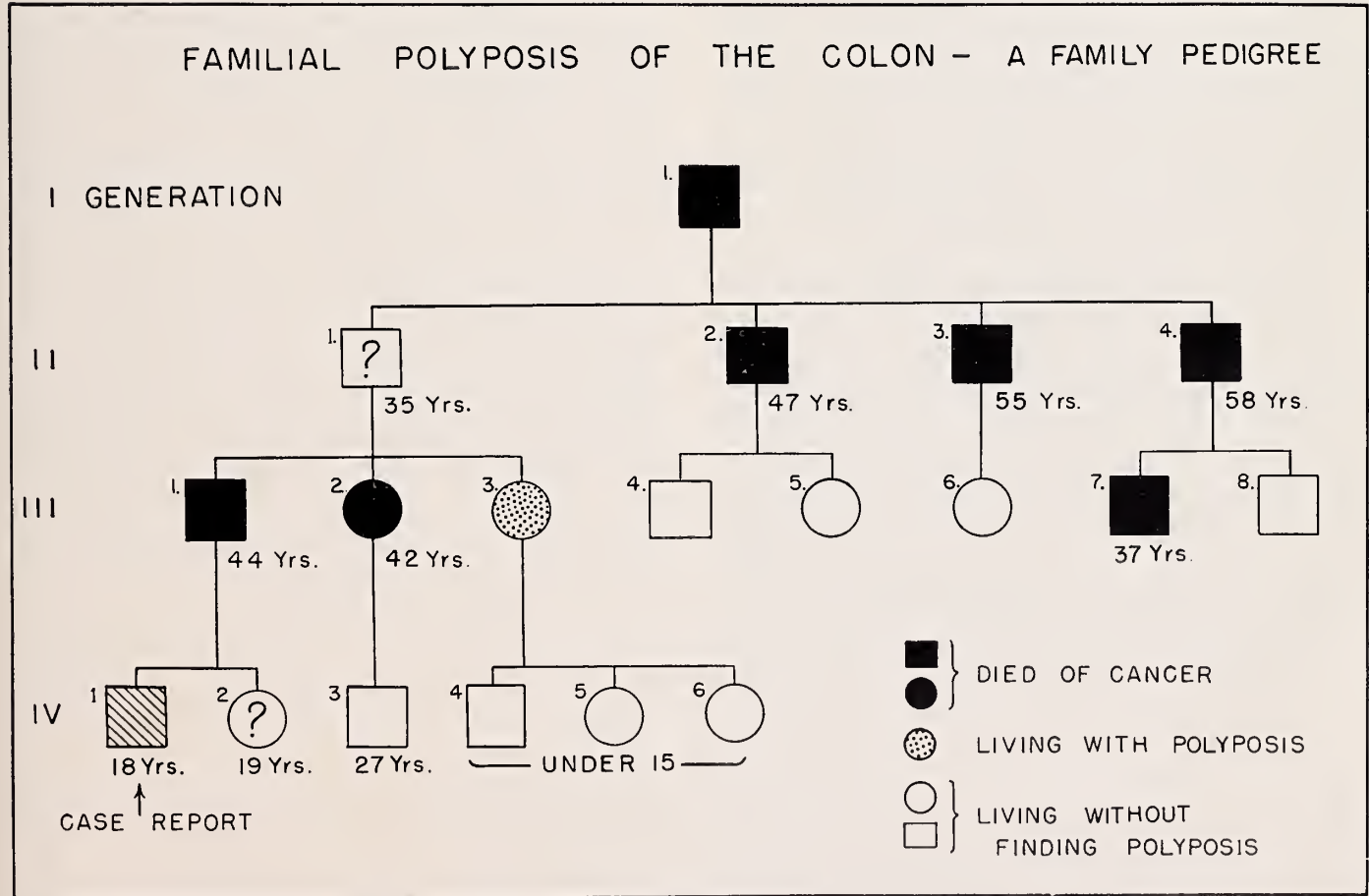


Figure 1
A Family Pedigree

eight cm. from the dentate line. It is intended that this patient be followed indefinitely, presumably examined every three months, and fulguration of any recurring or newly acquired polyps carried out at this time. It is believed that through this regimen, the danger of carcinoma developing in his rectum is remote.

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Letter to the Association Secretary

Re: The Eugene Talmadge Memorial Hospital

August 23, 1955

Dr. Henry Poer
384 Peachtree Street, N. E.
Atlanta, Georgia

Dear Dr. Poer:

I have been very much disturbed by the state of affairs that exists at the present time between the Board of Regents and the Medical Association of Georgia over the proposed operation of the Eugene Talmadge Memorial Hospital. Particularly I am disturbed because it seems to me that in a feud between these two, with the Medical School in the middle, that the latter is quite apt to suffer. I am quite sure that you are familiar with the past history of the Medical College, and how on two occasions it has lost its accreditation through no fault of its own, but by becoming embroiled in a row.

I am quite sure, too, that you realize Dr. Pund's position. The State has spent about fourteen million dollars on the new hospital and proposes to tax itself about three million dollars a year for the operation of the School and the Hospital. Dr. Pund is charged with the responsibility of putting this into operation at the direction of the Board of Regents. I am quite sure, too, that you realize that the opening of the School is at hand and that a start has to be made, and that the hospital itself must be put into operation. I am quite sure that you realize also what a hostile press might do for the Medical Association of Georgia

if it came out in bold headlines proclaiming that after spending all of this money the hospital could not be operated because it might financially hurt a few doctors.

I, of course, do not have any solution of the problem. It would be delightful from my point of view if it could be operated only for indigent patients, but it does seem to me that some middle of the road proposal might be found without stirring up so much controversy, and particularly without direct attacks on the School in the *Journal*. The Alumni of this particular school hold a very deep affection for it. Many of us could never have seen the outside of a Medical College had it not been for the reasonable fees here and the help that the Faculty was able and willing to give. If some of the very drastic proposals, which I have heard rumored the Council have been considering, are put into effect it will certainly create a great deal of ill feeling throughout the State, which will do neither the School nor the Medical Association of Georgia any good. I realize that you are not responsible for this state of affairs, but I do believe that perhaps you could help more than anyone else; and possibly it might help if some of the editorials were toned down a bit and that we not start out hunting a fight that we are almost certain to lose.

Very sincerely,

J. C. METTS, M.D.

Savannah, Georgia

The reply to the above letter will be found in the October issue of the *Journal*.

Maternal Rubella: Results Following an Epidemic

DARNELL L. BRAWNER, M.D., Savannah, Ga.

THE RELATIONSHIPS of congenital anomalies in the newborn to maternal rubella has been well established since Gregg¹ published his original paper. One of the major enigmas of this relationship, however, has continued to be the question of what proportion of infants would be born with an anomaly as influenced by the period of gestation in which the exanthem occurs. If conclusive results could be established, the problem of handling maternal rubella would be simplified. Reports on this aspect of the problem have shown considerable variations regarding the percentages of defective infants following rubella.

The pathology of rubella is secondary to the action of a filterable virus which gives rise to the exanthem in susceptible human beings. The diagnosis of rubella² is made mainly on the 12-24 hour prodromal stage of grippy malaise, the rose-pink, maculo-papular generalized rash, postauricular and posterior cervical lymphadenopathy, and the disappearance of the rash and other symptoms in less than 72 hours. It is important that rubella be diagnosed by as expert a physician as possible immediately upon appearance of the rash. If there is a delay of 12 hours before the patient is seen by a physician, the lesions may no longer be diagnostic and the management of the patient is uncertain.

The effect of rubella on the fetus is thought by Swann and colleagues³ to be a direct invasion of the virus through the placental barrier to the developing embryonic tissue. Since the majority of the anomalies traced to rubella etiology involve the heart, sensory organs, and brain, it seems the virus has a predilection for these tissues.

The theory has been proposed by Swann⁴ that embryonic tissues are more susceptible to injury by noxious agents during their most active period of development. This stage of organ development in the embryo occurs during the first eight weeks, and, consequently, one might anticipate specific injury to result from virus invasion at this period. Embryological studies⁵ reveal that the lens of the eye first appears as an ectodermal thickening during the

fourth week. The lens has detached from the ectoderm and lost its cavity by the eighth week. The partition of the primitive chambers of the heart begins between the fifth and sixth week, and the septa have been completed by the end of the seventh week except for the foramen ovale, which closes at the time of birth. The palate is formed by the union of the lateral palatine processes which begin to unite at the seventh week and complete the union at 9-10 weeks.

Since most of the active development of the embryonic organs has been completed during the first eight weeks of pregnancy, we would expect less injurious effects after the second month of pregnancy.

Other factors must be considered in explaining the fetal damage in maternal rubella such as the degree of virulence of the virus, the possibility of different strains of the causative organisms, and the possibility of misdiagnosing similar exanthems as rubella.

In the spring of 1952, a mild epidemic of rubella occurred in Chatham County, Georgia, and this investigation concerns the follow-up of the available cases of maternal rubella which resulted from the outbreak. Twenty-six cases of maternal rubella with their sequellae are listed in Table 1. Twenty-two cases were followed to the end of gestation and therapeutic abortion was done in four cases.

Rubella was diagnosed by history alone in five of the 26 cases, and by examination of a physician in the remaining 21 cases. This large number of cases diagnosed by physicians was due to the fact that considerable information was given the lay public regarding the dangers of rubella at the time of this epidemic.

Abnormalities were noted in six babies at birth, four of which were major and two minor. No abortions occurred, but one infant was delivered as a macerated stillborn at seven months gestation. The two minor abnormalities were slight lateral deviation of both ankles in one infant and mild muscular atrophy of both upper and lower extremities in another. The mothers of both of these infants had contracted rubella in the second trimester, and it is doubtful if the exanthem played a part in the development of these conditions.

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, Ga., May 1-4, 1955.

Table I

Sequella of Maternal Rubella in Relation to Period of Gestation

Case	Gestation Period (Menstrual) of Rubella	Diagnosis		Termination of Pregnancy	Condition of Baby at Birth
		History	Examination		
1.	6 Weeks		x	Term	1. Congenital Heart 2. Multiple facial anomalies
2.	6 Weeks		x	Term	Normal
3.	6 Weeks		x	Term	1. Harelip-Cleft Palate 2. Congenital Heart
4.	6 Weeks		x	7 Months	Macerated Stillborn
5.	8 Weeks	x		Term	Normal
6.	8 Weeks		x	Term	Bilateral Cataracts
7.	8 Weeks	x		Term	Normal
8.	10 Weeks	x		Term	Normal
9.	10 Weeks		x	Term	Normal
10.	10 Weeks	x		Term	Normal
11.	10 Weeks		x	Term	Normal
12.	10 Weeks		x	Term	Normal
13.	12 Weeks		x	Term	Normal
14.	12 Weeks		x	Term	Normal
15.	12 Weeks		x	Term	Harelip-Cleft Palate
16.	14 Weeks		x	Term	Atrophy muscles of arms and legs
17.	16 Weeks		x	Term	Ankle deviation
18.	16 Weeks		x	Term	Normal
19.	20 Weeks		x	Term	Normal
20.	20 Weeks	x		Term	Normal
21.	32 Weeks		x	Term	Normal
22.	38 Weeks		x	Term	Normal
THERAPEUTIC ABORTIONS					
23.	8 Weeks	"	"		
24.	8 Weeks	"	"		
25.	10 Weeks	"	"		
26.	10 Weeks	"	"		

The major abnormalities included one case of combined cardiac septal defect with harelip and cleft palate, one case of hare lip and cleft palate alone, one case of bilateral cataracts, and one case of cardiac septal defect combined with multiple facial anomalies.

The outcome of the infants in relation to the period of gestation in which rubella occurred is shown in Table 2. The cases occurring during the first trimester are divided into two groups, those in which rubella occurred during the first eight weeks of gestation and those in which rubella occurred from 8-12 weeks. This division was made to better

ascertain the most crucial time of fetal damage. Seven cases of maternal rubella occurred during the first eight weeks of gestation. Three normal infants were born following the disease at this stage, three showed anomalies, and one was a stillborn infant at seven months. Total fetal damage occurred at birth thus in 57 per cent of the infants whose mothers had had rubella during the first eight weeks of pregnancy. Eight cases occurred during the eighth through twelfth week of gestation, and one infant showed anomalies in this group, giving 12 per cent fetal damage. Five cases occurred in the second trimester, and two of the infants showed mild de-

Table II
Maternal Rubella in Relation to Trimester in Pregnancy

Period of Gestation (menstrual) that Rubella occurs	0-8 Weeks	8-12 Weeks	12-24 Weeks	24-40 Weeks	Total
Total Cases	7	8	5	2	22
Normal Infants	3	7	3	2	15
Abnormal Infants (including stillborns)	4	1*	2 (mild)	0	7
Percentage Fetal Damage	57%	12%	40%	0	32%

*Mumps at five months.

fects, giving 40 per cent fetal damage. The nature and mildness of these defects make it very doubtful if rubella could be blamed as the etiological agent. There were no abnormalities in two infants whose mothers had rubella in the last trimester of pregnancy. Thus the majority of fetal damage developed when rubella occurred during the first eight weeks of pregnancy. The infant defects, both mild and severe, amounted to 32 per cent of the infants of the 22 mothers.

The four major fetal anomalies and one intrauterine fetal death are shown in relation to the period of gestation that rubella occurred in Table 3.

Two cases of congenital heart defects combined with facial anomalies followed rubella at six weeks gestation. One fetus died in utero and was delivered at seven months; the mother had rubella during the sixth week of pregnancy. One baby had bilateral cataracts following rubella at eight weeks, and one infant was born with harelip and cleft palate following rubella at 12 weeks gestation. The type anomaly in relation to the embryology of the fetus is well correlated in all cases. The defect of the heart and the lens of the eye resulted from rubella that occurred during the most active period of embryological development of these organs. The oral defects can also be correlated since there is active development through the tenth week of embryonic life. We may also surmise, that sufficient damage occurred in the case of the stillborn infant to cause intrauterine death.

A one year follow-up has been obtained in 75

per cent of the cases reported normal at birth, and only one case has developed any abnormality. The remaining cases could not be contacted, but no report of any abnormalities reached their physicians. The case in which a defect developed after birth was an infant whose mother contracted rubella at six weeks gestation. When the infant was eight months old, she began having attacks of syncope at frequent intervals and has been diagnosed as having petit mal epilepsy. Other conditions such as deafness, idiocy, and malformation of teeth may occur later in the children who appeared normal at birth.

Comment

This series of cases of maternal rubella cannot answer on a statistical basis the important question of how to manage a pregnancy in which rubella has occurred. However, some information can be obtained from the present details. This study shows that all serious fetal damage occurred following rubella in the first trimester—33 per cent of the cases being abnormal. When rubella occurred in the first eight weeks of pregnancy, 57 per cent of the infants were damaged. The first eight weeks of pregnancy seems to be the crucial period in which rubella may produce serious changes in the fetal organs. A wide variety of anomalies has been reported following maternal rubella, but this investigation revealed an anomaly rarely reported, that of harelip and cleft palate which was seen in three cases, two in conjunction with congenital heart lesions and one showing the facial anomaly alone.

Table III
Type Anomaly in Relation to Period of Gestation

ANOMALY	PERIOD OF GESTATION (MENSTRUAL)
Multiple Facial Anomalies and Congenital Heart	6 weeks
Congenital Heart, Harelip and Cleft Palate	6 weeks
Macerated Stillborn	6 weeks
Bilateral Cataracts	8 weeks
Harelip and Cleft Palate	12 weeks

Summary

1. Twenty-two cases of rubella occurring during pregnancy are reported with the fetal outcome.
2. Fetal damage occurred in seven cases (32 per cent).
3. Fifty-seven per cent fetal damage occurred when rubella was contracted during the first eight weeks of gestation.

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Medical Aspects of Governors' Conference

GOVERNORS OF ALL STATES held a week-long conference in Chicago, and invited to one of their plenary sessions were Leo H. Bartemeier, chairman of the A.M.A. Council on Mental Health, and Council Secretary, Mr. Richard J. Plunkett. It was the first time in the 47 years' history of governors' conferences that medical specialists were asked to participate in a round-table discussion.

As chairman of the council, Dr. Bartemeier gave a graphic account of the broad mental health problem as it exists today. He called mental illness the "nation's No. 1 public enemy," and he told the governors that the greatest emphasis now should be placed on prevention of mental illness and promotion of mental health. As a result of his remarks, Gov. John F. Sims of New Mexico said later that these objectives could be carried out through a public relations campaign among voters and legislators interested in the problem.

Dr. Bartemeier suggested that much stronger emphasis be placed on the development of psychiatric units in all general hospitals, pointing out that community hospitals must assist in the work of treatment and prevention of mental illness. This requires, he said, not only the help of doctors, but of all community resources.

Among the problems confronting the governors themselves were inadequacy of trained staffs for mental hospitals and the tendency of one state to raid another state for personnel in about the same way that universities compete for football players. The need for increased funds for research also was stressed.

From a medical standpoint, one of the most important things coming out of the governors' conference was the approval and endorsement by official resolution of the new Joint Commission on Mental Illness and Health, sponsored and established by the American Medical Association, the American Psychiatric Association, and 20 other national organizations interested and working in the field of mental health.

Drs. Bartemeier and Plunkett acquainted the governors with the objectives of the joint commission in a memorandum which outlined, among other things, the objectives of the National Mental Health Study Act of 1955 which was enacted by Congress.

The objectives and purposes of the joint commission as stated in its articles of incorporation are:

(1) To study mental illness and mental health and the medical, psychological, social, economic, cultural, and other factors that relate to the etiology and course of development of mental illness, and to the advancement of mental health;

(2) To study ways and means of furthering the discovery, development, and application for all effective methods, practices, and therapies for the diagnosis, treatment, care, and rehabilitation of the mentally ill and retarded, and for the promotion of mental health;

(3) To study and advance ways and means of recruiting and training adequate personnel for the diagnosis, treatment, care, and rehabilitation of the mentally ill and retarded, and for the promotion of mental health;

(4) To survey all aspects of the problems of mental illness and mental health and to formulate comprehensive plans and programs for the improvement of all methods and practices for the diagnosis, treatment, care, and rehabilitation of the mentally ill and retarded, and for the promotion of mental health;

(5) To analyze and make available to the Congress, the Surgeon General, the governments of the several states, and other interested public and private associations, organizations, agencies, and persons, in annual and interim reports, or otherwise, the results of all studies and surveys mentioned in the preceding paragraphs.

The governors also were asked specifically to cooperate with the joint commission by lending the aid of their executive offices to the actual survey work which will begin late this year or early in 1956.

WHAT IS EXPECTED OF PHYSICAL MEDICINE

THAT MEDICAL SPECIALTY which deals with the diagnosis and treatment of disease by the use of heat, massage, exercise, electricity, and ultrasound is not an entity unto itself, but rather a supplement to other medical disciplines. The physiatrist employs his knowledge of physical agents and body mechanics in setting up a prescription for treatment or for a testing procedure which is carried out by a qualified therapist, just as a radiologist prescribes the views to be photographed and the dosage of x-ray to be administered.

Diagnostic procedures most commonly employed are: posture analysis for chronic and acute musculoskeletal pain, manual muscle testing, electrical stimulation, and electromyography. Results of these procedures are correlated with the history and with other physical findings before a final diagnosis is made. In most instances, malingering can be detected and objective evidence given. By repeated chronaxie determinations, reinnervation can be predicted; and by measurement of postural faults, a means of minimizing disabilities may be found.

Before prescribing treatment, it should be determined that definitive therapy is indicated, for only too often in this field, as in others, credit for success is taken by the physician when actually the natural healing process, time, and normal activities have effected the cure. The patient should be instructed in as extensive a home program as is possible within the limits of safety; results are obtained more quickly, the patient develops a more healthy attitude toward his disability, and his financial burden is less.

One of the most important contributions physical medicine can make is the prevention of serious disability in advanced years by the correction of posture faults and the teaching of proper body mechanics in the more active years. The surgeon and the nurse can avoid chronic backache by employing proper habits of bending and lifting, and by keeping stretched those tissues which promote improper skeletal alignment. The post-partum woman should avoid the debilitating backache of lordosis, and a prolonged illness in a business executive should not be complicated by de-conditioning.

The field of chronic diseases and geriatrics is an ever-increasing one, and the tax burden it imposes

will soon engulf us all if the principle of rehabilitation—"make the most of what is left"—is not utilized. Techniques of self-care can be taught to all except the most severely disabled; needless to say, the earlier they are instituted the better the result.

Psychosomatic manifestations are frequently found in the practice of physical medicine; and, if it is decided by all concerned that treatment should be given, caution must be exercised and treatment terminated at the proper time. Here a judicious therapist may be of the greatest aid in allowing release of frustrations and in helping to develop a healthy attitude.

The use of physical medicine in the treatment of a patient implies mutual responsibilities on the part of the referring doctor and the physiatrist. A history of present and past illness, physical findings, pertinent laboratory and x-ray findings, and social factors, together with a statement of the desired results are to be expected of the patient's physician. It is the responsibility of the physiatrist to inform his colleague of the results of examination, necessity for further consultation, and progress during treatment, and to terminate treatment when the limit of benefit to be derived from it has been reached. The patient should return to his physician with the feeling that all who have dealt with his illness have coordinated their best efforts.

Harriet E. Gillette, M. D.

UROLOGIC DIAGNOSTIC PROCEDURES

THE POET HAS OFTEN been the harbinger of sound progressive predictions as well as the challenger of the scientific man. "All are but parts of one stupendous whole whose body nature is and God the soul", so stated the poet. It is hardly within the province of the humble urologist to dwell upon the soul, but investigation into that part of life—the body—nature—is our firm charge.

The armamentarium of the urologist has for 40 or more years kept pace with other branches of medicine and indeed has often been the investigative leader. For proof, witness the work of Huggins and his co-workers in the field of cancer control.⁴ It is hardly necessary to recount the historical develop-

ment of urologic procedures or to attempt a recapitulation of urologic science, symptoms, diagnosis, and treatment. But if one were to review the histories of the urologic patient, he would be struck with the necessity of once again calling to the attention of all physicians certain important facts.

Pain need only be mentioned in passing, because medicine would indeed be able to advance its cause if all illnesses were accompanied by severe or persistent pain. No one seeks medical help so quickly as does the patient with pain. But the sight of blood, with or without pain, does not necessarily result in a complete medical examination. Gross hematuria indicates cancer of the urinary tract until proved otherwise. Adherence to this dictum will obviate diagnostic errors, and frequently it produces surprising pathology.

If the effort to establish the cause of hematuria is the most important urologic problem, a close second is that of cancer of the prostate gland which is seldom heralded by gross or microscopic hematuria. For adequate treatment of these two problems the urologist is almost entirely dependent upon his colleagues. For it is the observant practitioner who first sees the patient with hematuria and the male over 40 who is without urologic symptoms. Cancer of the prostate can be cured, but the cure rate is in direct proportion to the frequency with which the practitioner performs rectal examinations on the male over 40 years of age. The hard, fixed, non-tender, prostatic nodule indicates cancer until a biopsy proves otherwise. Available techniques for biopsy are harmless, inexpensive, and gratifying indeed. If cancer is not present, no harm is done, but the positive biopsy will at the same sitting permit total excision of the neoplasm and offers a high cure rate.⁵ The detection of unsuspected occult carcinoma following a transurethral prostatic resection for benign hypertrophy must not lead to failure to totally excise the prostate at a subsequent date.³ In some areas of the country enthusiasm is high for the detection of occult prostatic cancer by staining prostatic smears after vigorous massage. Such enthusiasm is local and has not been adopted nationally.

Recurrent or persistent urinary tract infections demand the usual urologic investigation including radiographic studies of the urinary system as well as cystoscopy. The child with infection poses a problem somewhat different from that of the adult. All too often excretory urograms of the child's urinary tract are reported to be within normal limits. Cystoscopic studies may be equivocal. The advantages of

cystography has recently been re-emphasized by St. Martin.⁷ If a cystogram is performed by first filling the bladder with contrast media and a second x-ray taken while the patient is voiding, a third film made after the patient has voided may reveal ureteral dilatation, transient hydronephrosis, and residual urine. The most common cause of such decompensation of the urinary tract is vesical neck pathology which can be surgically corrected.

Of the modalities available to the urologist three recently introduced are intriguing and offer new avenues of diagnostic approach. Pre-sacral air injection⁶ offers a safer method for the retroperitoneal introduction of air than the older flank approach. Diagnosis of renal, suprarenal, or retroperitoneal masses is enhanced by this simple procedure which is performed under local anesthesia. When pre-sacral air injection is combined with retrograde pyelography and aortography, one gains a composite picture of the retroperitoneal organs which often leads to a clarification of the occasionally puzzling problem. Aortography¹ is likewise a simple, innocuous procedure which at times permits the study of renal parenchymal changes as well as another method of renal function study. Quite recently introduced is a delightful technique which will under certain conditions permit renal function study. Percutaneous antigrade pyelography² is accomplished by directly inserting a needle into the kidney through the flank. Contrast media are injected into the kidney through this trocarneedle after which an x-ray is made, and the renal outline is obtained. When visualization by excretory or retrograde pyelography is impossible, percutaneous antigrade pyelography permits pre-operative study of the kidney. If temporary drainage is desired, a polyethylene catheter can be inserted through the trocarneedle and left indwelling as a nephrostomy catheter until definitive surgery can be performed.

While it is not usually within the province of the urologist, needle biopsies of the renal parenchyma can be obtained with impunity to permit study of the nephron units.

The introduction in recent years of new modalities has increased the diagnostic efficiency of the urologist. By combining the techniques which have been available during the past 40 years with new procedures, the genito-urinary surgeon is indeed able to offer his medical colleagues and the patient a high standard of medical care.

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NEW MEMBERS INDOCTRINATION

A NUMBER OF STATE and county medical societies have adopted "indoctrination programs" for new members. These programs often consist of a special meeting held to explain the importance of medical organizations and the various activities on the county, state, and national levels. At these meetings new members are given copies of the organization's constitution and by-laws and are generally oriented as to the purposes and aims of organized medicine.

The societies which have adopted such indoctrination programs have realized the tremendous importance of membership in a medical organization, a fact often overlooked by the county medical societies that make up the Medical Association of Georgia. It is a fairly common practice for new members to be taken into small medical societies at the first meeting which they attend, when no application for membership has been submitted and when the presence of the new member at the meeting pre-

vents any discussion as to his qualifications for membership. In other instances it has been reported that physicians have been taken into fairly large county medical societies and have not attended a single meeting since their admission.

The importance of membership in a county medical society cannot be stressed too much when one realizes that a physician upon admission to a local medical society is automatically admitted to the MAG and the AMA. Even more than this, the newly elected member has in a sense received the stamp of approval from his fellow physicians, and this stamp of approval should not be taken too lightly.

It is often better to refuse membership to an undesirable physician than to try to revoke his membership after he has become a member. Every new member should be carefully examined by the Board of Censors and the entire membership of the society.

At a meeting of the Bibb County Medical Society recently, a very effective method of electing new members was observed. After the applications had been approved by the Board of Censors at a previous meeting, the entire membership of the society was asked to vote on the new members by secret ballot, and the name of each applicant had to be written on the ballots.

Of course, there are many ways to elect new members, and they will vary according to the size of the society. It behooves the profession to keep its own house clean, and careful screening of all new members is one of the best ways to accomplish this end.

Once a physician has become a member it becomes the responsibility of the older members to indoctrinate him as to the importance of the society's activities and purposes.

Kinescopes of "Physicians' Conference on Cancer"

THE GEORGIA DIVISION of the American Cancer Society, 2025 Peachtree Road, N. E., Atlanta 9, has a series of kinescopes available for showing to medical society and hospital staff meetings. They also have a five minute motion picture film which shows scenes from several of these kinescopes. Titles of available kinescopes are listed below:

The Psychological Aspects of Cancer
Cancer Detection
Lymphomas and Leukemias
Cancer of the Urinary Bladder

Cancer of the Oral Cavity
Cancer of the Prostate
Tumors of Childhood
Moles and Melanomas
Chemotherapy: A Research Frontier
Cancer of the Thyroid
The Differential Diagnosis of Uterine Bleeding
Cancer of the Cervix
Cancer of the Colon and Rectum
Tumors of Bone
Head and Neck Cancer



Any Change in Wart or Mole

ENOCH CALLAWAY, M.D., LaGrange, Ga.

THE FOURTH DANGER SIGNAL of the American Cancer Society's lay education program combines two different entities. The changes in moles suggestive of melanoma have been considered in a previous article, therefore, in this article the subject will be confined to warts.

The common warts of childhood are usually transient and need no discussion or treatment. The small multiple warts in the beard area on men's faces are apparently transferred as grafts when shaving and are usually best treated by fulguration. These offer no diagnostic problem.

The wart that may be malignant is usually one centimeter or more in diameter and clinically has the same appearance as a verruca vulgaris. No indurated base can be felt, and most of the growth projects above the skin level. We have found these on the lip, cheek, neck, and on the dorsal surface of hands, arms, fingers, and the foot. Ewing states that warts may undergo malignant changes. From my observations, I believe that the wart is produced by the mechanical irritation of a small keratosis and that the keratosis is the basis of the development of a squamous carcinoma.

Fulguration of a wart of any appreciable size produces scarring and a slow healing wound in addition to destroying material for pathological examination. Curretment is not only an excellent method of obtaining tissue, but is also the most satisfactory method of curing a wart.

Under novocaine anesthesia, using a number one bone currette, which I have found to be more desirable than the skin currettes on the market, the lesion is removed and the base thoroughly scraped. Any overlapping skin edges are trimmed off with a small pair of scissors. If the wart develops on very thick or very tough skin the upper layer of the skin along the edge of the wart may be shallowly incised with a knife, or the skin may be clipped with the scissors prior to curretment. After the lesion has been completely removed, the base is touched with a silver nitrate stick and pressure applied to control bleeding. Any mild ointment may be used as a dressing. As a wart develops above the basal layer of the skin, healing will take place with no scarring. If the lesion is malignant the base will usually not be smooth and glistening, but will have a more or less moth-eaten appearance.

If, on tissue examination, malignancy is found, the lesion may be treated by surgery, x-ray, or radium as deemed advisable. These lesions are not usually markedly invasive, and I have not had any metastases to nodes following the use of this technique.

Lesions clinically identical to warts may be squamous carcinomas. When these are found on the exposed body surfaces of adults, they should be viewed with suspicion and tissue obtained for pathological examination. A method found satisfactory has been described.

New Members of the M. A. G.

<i>Name</i>	<i>Address</i>	<i>County Society</i>	<i>Classification</i>
William S. Compton	Crawford W. Long Memorial Hospital, Atlanta	Fulton	Associate
John A. Ferrence	Whigham	Grady	Active
W. F. Durden	445 N. Pryor St., Gainesville	Hall	Active
William P. Nicolson, III	111 N. Main St., Gainesville	Hall	Active
S. O. Poole	608 E. Broad St., Gainesville	Hall	Active
Joseph T. Christmas	Vienna	Flint	Active
Robert S. Robinson	Vienna	Flint	Active

Clinical Recognition and Treatment of Acute Streptococcal Pharyngitis and Tonsillitis

DANIEL D. HANKEY, M.D., Atlanta, Ga.

STUDIES DURING THE PAST two decades have revealed that the streptococcus is one of the major pathogens of man. Streptococcal pharyngitis and tonsillitis is the most common disease produced by this organism. In almost all cases the causative agent is the beta-hemolytic streptococcus.

Streptococcal infections in the throat usually occur endemically although epidemics are occasionally seen. They are most common in children and young adults and are seen most frequently in the winter months. The organisms are usually spread by droplet infections and settle in the lymphoid tissue of the oropharynx or the tonsils.

The incubation period is usually three to five days followed by the acute onset of fever, chilliness, headache, and sore throat. After 24 hours, the temperature reaches a maximum of 101 to 104°, and the patients are acutely ill. Swallowing is difficult and painful. A dry hacking cough may be present but hoarseness is very unusual.

The examination of the patient at this time shows fever, tachycardia, and diffuse redness and edema of the mucus membranes of the throat including the posterior pharyngeal wall, tonsils, pillars, and soft palate. The lymphoid follicles on the posterior pharyngeal wall are usually hypertrophied and prominent. A discrete or confluent exudate is present on the tonsils or pillars and may be pale yellow, gray, or white. A cotton swab rubbed over the exudate will remove it with ease. In some patients no exudate is present, but the throat still is characteristically red and edematous. Enlarged upper cervical nodes are present and are almost always very tender.

Laboratory work reveals an elevated white blood count to 15,000 or more with a shift to the left in the differential. The urine commonly shows a trace of albumin which is a non-specific response to fever. Throat culture on a blood agar plate will reveal beta-hemolytic streptococci.

The diagnostic features of streptococcal pharyngitis and tonsillitis include (1) abrupt onset with fever and sore throat, (2) redness and edema of the pharynx, tonsils, and soft palate with a discrete-to-confluent yellow or white exudate, (3) large tender cervical lymph nodes, and (4) elevated white blood count with a left shift in the differential.

The differential diagnosis included *infectious mononucleosis*. In this disease the onset is usually more insidious. The throat may be very similar to that in streptococcal pharyngitis and tonsillitis even with an exudate. The patients are not as acutely ill, and they complain of malaise and lassitude. The lymph node enlargement is present but commonly is generalized, and those in the cervical chain are not so tender. Splenomegaly favors the diagnosis of infectious mononucleosis. The differential white blood count shows an increased number of lymphocytes, and atypical lymphocytes may be found by the experienced technician. *Diphtheria* is considered in the differential diagnosis. The onset is rarely sudden as in streptococcal pharyngitis and tonsillitis, and severe sore throat is not characteristic. The exudate is confluent and is difficult to remove with a swab. It has the appearance of a membrane over the tonsils and/or pillars. Culture of the exudate will reveal the correct diagnosis. *The pharyngitis and tonsillitis of viral origin* may be associated with an exudate and must be excluded. The onset is usually insidious and the patients are not acutely ill. The sore throat is only moderate, examination of the throat reveals it to be not as fiery red as in streptococcal infections, and the exudate is usually discrete rather than confluent. The cervical lymph nodes are enlarged but not strikingly so and are not tender. The white blood count is usually normal. *Vincent's angina* is usually unilateral, and the fiery red throat is not present. Fever and constitutional symptoms are unusual.

The treatment of choice of streptococcal pharyn-

gitis and tonsillitis is penicillin. Many different dosage schedules have been recommended. The American Heart Association feels that adequate treatment may be obtained by: (1) a single injection of 1.2 million units of benzathine penicillin, (2) 600,000 units of procaine penicillin every other day for three

to four doses, (3) a daily dose of 300,000 units of aqueous penicillin for 10 days, (4) or at least 500,000 units of penicillin by mouth daily for 10 days. Suppurative complications occur (otitis, sinusitis, mastoiditis, treatment should continue until these conditions are cleared.

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.

Wider Knowledge of Chemical Health Hazards Needed

THE THOUSANDS OF CHEMICAL products developed to make life simpler may only complicate it unless used with care and intelligence.

The Committee on Toxicology of the American Medical Association has said that there are about a quarter of a million brand name chemical products which may be used in the home, farming, and industry.

All of them may be useful—but handled improperly they may become killers, cripplers, and destroyers of property.

Understanding of the uses and the potential dangers of the wealth of products available is needed to prevent the estimated 3,300 accidental poison deaths which result each year from misuse of chemicals.

The array is so large and so many combinations of chemicals are possible that no complete catalogue of all available products has been made, the committee said.

As part of its campaign to spread information about these products and their hazards, the committee will sponsor a symposium on health hazards of chemicals Dec. 29 during the annual meeting of the American Association for the Advancement of Science, in Atlanta, Ga.

Bernard Conley, Ph.D., secretary of the A.M.A. Committee on Pesticides—which is co-sponsoring the discussion—will be moderator for the symposium. He said the purpose of the meeting is to interpret new knowledge of chemical products to scientists in various fields, so they may in turn use and spread the information.

The committees are working toward development of more intelligent use of chemicals so that their

advantages may be enjoyed without dangerous results, Conley said. They do not mean to imply that potentially dangerous chemicals should not be used at all.

“The problem of health hazards has increased with the wider household use of chemicals once found only in industry,” he said. “This makes misuse more serious and the necessity for widespread knowledge more urgent.

“There are several thousand basic chemicals used in available products; these can be mixed in an infinite number of combinations and sold under an infinite variety of fanciful names. The products can be changed in composition without notice and even patent office records don’t necessarily show the present composition. Thus, a listing of the contents of all brand-name products is impossible to make.”

Conley said while no one may know all about all of these products, the danger of poisoning would be greatly reduced by wider understanding of the problem, reasonable care in using any chemical, and careful attention to label instructions.

On the AAAS meeting symposium devoted to the problem in the home, agriculture, and industry will be Lester M. Petrie, M.D., director, preventable diseases service of the Georgia Department of Public Health, Atlanta; Wayland J. Hayes, M.D., chief of the toxicology section of the Communicable Diseases Center, U. S. Public Health Service, Savannah; Irvin Kerlan, M.D., associate medical director of the federal Food and Drug Administration, Washington; and Mrs. Veronica Conley, assistant secretary of the A.M.A. Committee on Cosmetics, Chicago.



abstracts by georgia authors

Papageorge, Evangeline, and Nancy Lee Noble, Emory University School of Medicine, Emory University, Georgia. "Adrenal Glycogen in the Guinea Pig and in the White Rat", J. Nutrition 56:15-24 (May) 1955.

Adrenal glycogen concentration was established in young, adult, male guinea pigs and albino rats, and the effect of altering nutritional state was studied. Glycogen was assayed colorimetrically by application of the anthrone reaction following customary isolation by ethanol from alkaline digests. The technique proved reproducible for 20- to 40-microgram samples of glycogen, and compared favorably with Nelson's sugar method applied to acid-hydrolyzed polysaccharide isolated from duplicate tissue aliquots.

The glycogen of guinea pig adrenals averaged 25 mg. per 100 gm. fresh tissue. It was slightly elevated by fasting but was not significantly affected by level of ascorbic acid intake.

Rat adrenal glycogen, however, averaged 184 mg. per cent after eight to 48 hours of fasting, and was only 2/3 as much or less if glucose or fructose was given one to four hours before sacrifice or when no fast was imposed. About 1/2 of the glycogen isolated from alkaline digests of rat adrenal represents a fraction which can be readily extracted from fresh tissue with 10 per cent trichloroacetic acid.

Shea, Patrick C. Jr.; L. F. Glass; W. A. Reid; and Arthur Harland, 69 Butler St., S. E., Atlanta, Ga. "Anastomosis of Common and Internal Carotid Arteries following Expansion of Mycotic Aneurysm", Surgery 37:829-832 (May) 1955.

The rarity of reports in the surgical literature on successful cases of end-to-end anastomosis of the common and internal carotid arteries following excision of a defective portion indicates that two instances within a period of 14 months in the experience of one surgeon are most unusual.

In the present instance, an estimated deficiency of 4.5 cm. resulted from excision of an arterial aneurysm.

A 58-year-old Negro man was admitted to the surgical service of Grady Memorial Hospital with a diagnosis of aneurysm of the left common carotid artery. The patient was hospitalized for study and observation. The mass enlarged rapidly. Just before operation it was impossible to insert a finger between the superior pole of the aneurysm and the mastoid process, and inferiorly the index finger could barely be interposed between the margin and the clavicle. The trachea was pushed far to the right and lay beneath the right sternocleidomastoid muscle.

Complete excision of the aneurysm was accomplished. End-to-end anastomosis of common and internal carotid arteries was effected. The case report presents details of the procedure and artist's concept of operative technic. Postoperative arteriograms demonstrate a patent anastomosis. The pathologist's diagnosis: Mycotic aneurysm superimposed on syphilitic disease of the carotid artery.

Steadman, Henry E., 3021 Stewart Ave., Hapeville, Ga. "Lymphosarcomas of the Colon", Proc. Internat'l. Coll. Surg., Meeting May 23-26, 1955, Geneva, Switzerland.

Two unusual cases of lymphosarcoma of the right colon, both involving the caecum, are presented. Both patients were white women, 69 and 73 years of age. Both were treated by surgical removal of the tumour followed by deep X-ray therapy. Both are living and seem to be free of tumour. Nitrogen mustard and radio-isotopes are mentioned. The literature reveals that lymphosarcoma of the colon is rather rare occurring in less than one per cent of all malignant lesions of the colon. Lymphosarcomas, like other sarcomas, are more frequent in children than adults. It is two to three times more common in males than in females. It is generally more common in the colon than in the small bowel and in the first three or four decades of life than later. The prognosis depends on the age of the patient, whether the tumour is isolated or widespread and can be removed surgically, and the type of the tumour cell. Prognosis may be more favourable than in carcinoma, especially in the stomach and in the small bowel. Diagnosis is usually made at operation. In the presence of widespread lymphatic involvement, lymphosarcoma should be suspected. The following may be found: (1) anaemia; (2) weakness; (3) loss of weight; (4) lack of vigour and energy;

(5) abdominal cramps; (6) abdominal distension; (7) change of bowel habits as diarrhea, constipation or alternation of both; (8) signs of intestinal obstruction such as distension, obstipation, colicky pains, vomiting; (9) blood in stools late after ulceration, and (10) mass that is palpable. The treatment used is standard. The lesions are removed surgically whenever possible. X-ray treatment is used postoperatively.

Manganiello, Louis O. J., and Pomeroy Nichols, Medical College of Georgia, Augusta, Ga. "Intraventricular Torula Granuloma", J. Neurosurg. 12:305-310 (May) 1955.

This is the first case recorded in the literature of the intraventricular granuloma of the choroid plexus due to torula histolysis. 15 cases have been reported in the literature of cerebral granulomas but none were reported on the intraventricular. This is a case reported of a 61 year old white male who was admitted to the hospital with signs of dizziness, headaches and malaise, and right sided weakness. Cultures of the spinal fluid did not reveal any evidence of the organism at first, and it was only 18 days after the first culture that it became positive. In the meantime air studies were done which revealed a mass in the right lateral ventricle. This turned out to be a Torula Granuloma. The patient died and an autopsy was done.

This man was a carpenter by trade and it had been brought to our attention five of eight cases of torula infection of the central nervous system that their occupation was associated with the wood pulp and paper industry.

Rhode, C. Martin, and Richard T. Shackelford, V. A. Hospital, Forest Hills Division, Augusta, Ga. "Sacrococcygeal Chordoma, Its Surgical Treatment", Ann. Surg. 141:952-966 (June) 1955.

Sacrococcygeal chordomas are malignant tumors which are encapsulated and are characterized by their slow progressive growth and their tendency to recur after inadequate surgical excision. Metastases were only mentioned in 10% of the reported cases. A more radical surgical excision has been suggested by the authors. They feel that the sacral canal should be explored as a predetermined and formal part of the operation before the level of transection of the sacrum has been selected. In the article there are numerous photographs and legends regarding the techniques of this procedure. It has been well established that the 4th and 5th sacral nerves bilaterally, as well as one of the 3rd sacral nerves can be sacrificed, and urinary and fecal continence will be maintained. It is further emphasized that an adequate margin of adjacent soft tissue should be removed, since chordoma cells have been found within the capsule of the tumor. So-called enucleation of the tumor, at the level of the capsule, will almost surely leave in chordoma cells which would form a nidus for recurrence.

The authors present case histories of their two patients in detail.

Sidbury, James B., Johns Hopkins Hospital, Baltimore, Md. "Lead Poisoning", Am. J. Med. 18:932-946 (June) 1955.

Disodium Calcium Versenate (CAEDTA) has been used in the treatment of over 35 patients with lead poisoning; nine illustrative cases are reported. The rationale of therapy is discussed and a suggested dosage regimen is outlined which is practical for out-patient treatment.

The results of therapy were very gratifying, and no untoward reactions were encountered using the recommended dosage.

The role of the internist and the general practitioner in the diagnosis and treatment of lead poisoning is emphasized.

Stewart, P. A.; H. J. Grossman and William Kadetz, Emory University School of Medicine, Emory University, Ga. "Resistance Strain Gauges Applied to Respirometry: A New Method for Studying Respiration in the Newborn Infant", J. Lab. & Clin. Med. 46:121-127 (July) 1955.

To meet the problem of measuring respiration in very young infants, a respirometer has been devised which uses resistance strain gauges as its sensitive elements. Due to its light weight and small size, this device causes negligible discomfort or restraint. The respirometer is simple to construct and use and may be easily modified to suit a variety of applications. A description of the respirometer and some sample records are given.

doctor placement page



NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

AVAILABLE PHYSICIANS

Anthony, James E., Jr., M.D., Presbyterian Hospital, 1753 West Congress St., Chicago 12, Illinois—Age 32; married; Methodist; graduate University of Maryland, 1947; residency Jefferson Hospital, Roanoke, Va.; Emory University Hospital, Atlanta; Presbyterian Hospital, Chicago, Ill.; specialty surgery; available June 1957.

Archibald, Donald Harper, M.D., 15 McElaney Drive, Black Pt. Road, Niantic, Connecticut—Age 55; married; Presbyterian; graduate Dalhousie University, Halifax, N. S., 1936; residency (Pathology) St. Vincent's Hospital, New York City, two years; Assistant Surgeon, St. Anne's DVA Hospital, Montreal, 2½ years; available now.

Bell, John Arthur, M.D., 651 East 14th Street, New York 9, N. Y.; Married; Protestant; graduate Cornell University Medical College, 1949; residency II (Cornell) Medical Division, Bellevue Hospital, N. Y. C.; available July 1, 1955.

Calkins, Robert S., M.D., 8983 Mission Boulevard, Riverside, Calif.—Age 36; married; Presbyterian; graduate Oklahoma University, 1947; residency Presbyterian Hospital, Philadelphia, Pa.; specialty O. B. Gyn; available now.

Campbell, Roy E., M.D., Valley Forge Army Hospital, Phoenixville, Pennsylvania—Age 36; married; Baptist; graduate Emory Medical School, 1943; residency Grady Memorial Hospital, Atlanta; at present in Army will leave in July, 1955; has a Georgia and Florida license; available July 10, 1955.

Compton, William S., M.D., 3256 East Huntington Drive, Decatur, Ga.—Age 29; married; Presbyterian; graduate Medical College of Georgia; residency one year Crawford W. Long, Atlanta, Ga.; available August 1, 1955.

Damron, John R., M.D., 216 Pearl St., Jackson, Ohio—Age 30; married, two children; Methodist; graduate University of Louisville, 1952; residency intern St. Vincent's Hospital, Toledo, Ohio. Interested in general practice in community of 8,000 or larger. Available now.

Law, William, M.D., Mayo Clinic, Rochester, Minnesota—Age 31; married; Baptist; graduate Medical College of Virginia (Richmond) 1948; residency Medical College of Virginia (Richmond), Junior Assistant and Assistant resident, Mayo Clinic three years fellowship in medicine; interested in practice in clinic.

Mason, Roscoe E., M.D., Surgical Service U. S. Army Hospital, Fort Bragg, North Carolina—Age 32; married; Methodist, graduate Harvard Medical School, 1948; residency Boston City Hospital 13 months remainder including chief residency at Tripler General Hospital (U. S. Army) Oahu, T. H.; expect to be discharged August 1, 1955; available 1-15 August, 1955.

Melcher, Truman O., M.D., ENT Clinic, John Sealy Hospital, Galveston, Texas—Age 41; married; Protestant; graduate University of Texas School of Medicine, 1942; residency John Sealy Hospital; member AMA; specialty otolaryngology and endoscopy; available September 1, 1955.

Veal, Molloy G., Jr., M.D., 2511 Dumesnil, Louisville, Kentucky—Age 34; married; Protestant, graduate University of Louisville (Kentucky) 1948; residency Brooke Army Hospital, Ft. Sam Houston, Texas; specialty, internal medicine; available now.

AVAILABLE LOCATIONS

Arlington, Georgia (Calhoun County)—Population 1,382. In need of doctor-surgeon for practice in new excellently equipped 16-bed hospital, located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia.

Atlanta, Georgia (Fulton County)—Needed immediately, young man doing general medicine interested in association with established X-Ray and clinical laboratories. Contact: Drs. Landham & Klugh, 736 Piedmont Avenue, N.E., Atlanta, Georgia.

Braselton, Georgia—(Jackson County)—Doctor must now come from one of following places; Jefferson, 10 miles; Winder, 10 miles; Lawrenceville, 20 miles; Gainesville, 20 miles; Buford, 20 miles. Have a well equipped clinic and a home rent free. Clinic is rent free and home until doctor can afford to pay rent or buy a home. Possible that home will be furnished free.

Broxton, Georgia (Coffee County)—Population 3,500—Doctors clinic available; also home available; 60 room county hospital at Douglas; seven room doctors building; no physician in area; physician will have more work than he can do. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia.

Dillard, Georgia (Rabun County)—Population 2,500. Doctor's office to be furnished rent free for one year; would rent

five or six room house, fully equipped kitchen, county hospital at Clayton; drug store and pharmacist; good schools; doctor would be welcome right now; late doctor had an excellent practice; other benefits considered in a short time; active church groups and community club that would be happy to assist doctor. Contact: Mrs. L. Neville, Dillard, Georgia.

Edison, Georgia (Calhoun County)—Population 1,245. Two physicians in area; Hill-Burton Hospital (1 mi.); one clinic local with 10 beds, x-ray, lab equipment, operating room with instruments; rental \$75.00 (maximum \$100.00) per month; two excellent drug stores; housing available for rent at \$30-\$40; good elementary and high schools; five churches; great need for a physician in this community. Contact: Dr. J. S. Beard, Edison, Georgia.

Hampton, Georgia (Henry County)—Population 1,000—No doctor in Hampton, nearest 10 miles away; hospital in Griffin; office space, housing available; contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia.

Jeffersonville, Georgia (Twiggs County)—One physician in area doing limited practice; hospital facilities nearby in Macon; office space available with small rental or purchase; one drug store with registered pharmacist; house made available immediately; 69 lakes stocked with bass brim or trout; 150,000 acres woodland makes Twiggs County good hunting ground for small game; definite need for physician. Contact: Mr. H. C. Swearingen, Jeffersonville, Georgia.

Smithville, Georgia (Lee County)—Population 700—No physician in area; home in Leesburg, office downtown rent free; completely equipped office of two rooms and connecting lavatory with outlets for sterilizers, etc., attached. All Contact: Mr. E. H. Conner, Unadilla, Georgia.

Unadilla, Georgia (Dooly County)—Population 1,200—Dooly County Hospital owned and operated by the people of the county; office space available or will build small clinic and let doctor rent or buy. Housing will be provided rent reasonable or can get house built to suit. They guarantee a good doctor will do well; one physician in area, age 75.

Woodbine, Georgia (Camden County)—Population 1,000. Small, fully equipped office and clinic available; ample office space, delivery room, laboratory (inc. x-ray), nursery, wards, private rooms; five room wooden dwelling adjoins hospital available at \$35.00 mo.; one other doctor in Woodbine, doctor is needed now. Contact: Dr. S. C. Atkinson, Waverley, Ga.

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. . . when a location has been filled



physician's bookshelf

BOOKS RECEIVED

BOOKS RECEIVED

The Council on Pharmacy and Chemistry, American Medical Association, *New and Nonofficial Remedies*, J. B. Lippincott Company, Philadelphia, 1955, 653 pp., \$3.50.

Everything and the Kitchen Sink, Farrar, Straus and Cudahy, New York, 1955, 160 pp., \$4.00.

Stott, C. P., S.R.N., C.M.B., and M. Fischer-Williams, M.R.C.P.Ed., *The Management of Acute Poliomyelitis*, E. & S. Livingstone Ltd., Edinburgh and London, The Williams and Wilkins Company, Baltimore, 1955, 99 pp., \$3.00.

Bantarow, Abraham, M.D., and Trumper, Max, Ph.D., *Clinical Biochemistry*, 5th Edition, W. B. Saunders Company, Philadelphia, 54 figures, 738 pp., \$9.00.

REVIEWS

Andrews, George Clinton, M.D., F.A.C.P., *DISEASES OF THE SKIN, FOR PRACTITIONERS AND STUDENTS, FOURTH EDITION*, W. B. Saunders Company, Philadelphia and London, 1954, 887 pages, 777 illustrations, \$13.00.

This new edition of what has now become a standard text book of dermatology is up to its usual high standard.

Dr. Andrews has placed a greater emphasis on histopathology with much better photomicrographs. The chapters on skin tumors and pigmented nevi and melanoma have been rewritten, and reflect the refinements and knowledge of these subjects as have occurred in the past eight years.

The discussion of the lupus erythematosus phenomena and the skin appearance associated with internal cancer has been added.

In general his discussion of management and treatment of most of the common dermatoses is much improved. While the index seems adequate, one is a bit disappointed in the bibliographic details, but, after all, this book is primarily a text book for the general practitioner of medicine and for medical students. It can be highly recommended for a prominent place on any doctor's book shelf.

Herbert S. Alden, M.D.

Ochsner, Alton, M.D., F.A.C.S., and DeBakey, Michael E., M.D., F.A.C.S., (Editors) *CHRISTOPHER'S MINOR SURGERY, SEVENTH EDITION*, W. B. Saunders Company, Philadelphia, 1955, 547 pp., \$9.00.

This book, as in previous editions, is a leader in this phase of surgery. One is impressed with the fact that minor surgery demands an equal degree of obligation as does major surgery.

The book is somewhat overdue, seven years having elapsed since the previous edition; therefore many new advances have been added. Because of the new additions and many changes it may virtually be called a new book. The biggest change in this edition is the use of multiple authors, giving us the advantages derived from such varied special interests.

It is especially helpful to the house officer and young surgeon and for quick accident room reference; as a matter of fact a chapter is devoted to The Surgical Resident. It's readability is excellent. As has frequently been quoted "For every major case a surgeon sees, there are five minor ones." The book covers many practical suggestions that of necessity have to be omitted in a busy medical school curriculum.

Illustrations could have been more numerous without overloading the book, but those that are included are good.

The book is highly recommended.

Charles H. Watt, Jr., M.D.

Stanbury, John B., M.D.; Brownell, Gordon L., Ph.D.; Riggs, Douglas S., M.D.; Perinetti, Hector, M.D.; Itoiz, Juan, Ph.D., and del Castillo, Enrique B., M.D., *ENDEMIC GOITER, AN ADAPTATION OF MAN TO IODINE DEFICIENCY*, Harvard University Press, Cambridge, 1954, 206 pp., \$4.00.

This small monograph of 206 pages describes some interesting research work in finding the cause of goiter which was carried out under very unusual conditions. To take the laboratory into the field and study at the source a group of patients with endemic goiter is an event in itself, and the authors' account makes worthwhile reading.

While no epoch-making discoveries resulted, the laboratory data and clinical information obtained will make this work a valuable addition to our information on this subject. The book is well edited and the material presented in clear cut fashion that is easy to comprehend.

David Henry Poer, M.D.

Stevenson, George S., M.D., *ADMINISTRATIVE MEDICINE (Second Conference)*, Josiah Macy, Jr. Foundation, New York, 1954, 159 pages, 11 illustrations, \$3.00.

While the value of this book is limited, it affords an insight into some of the problems of Administrative Medicine, and presents an interesting discussion on Home-Care Programs and the Health Service of the Department of Health of Scotland.

The participants and the guests are authorities in their fields and the informal manner of the discussions are interesting and helpful.

Edgar R. Pund, M.D.

This biography, *Casimir Funk: Pioneer in Vitamins and Hormones*, presents the first full length word portrait of this important scientist. The reviewer can only touch on the highlights of a crowded, achievement-filled career as narrated by the author, a scientific and longtime personal friend of Dr. Funk.

Born of a noted Polish dermatologist who influenced him profoundly, Funk pursued his studies in biochemistry in Berne, London, Paris, and other cities throughout the world. It was in Berne, at the age of 20, that he did his first experimental work with hormones and became a Ph.D. This was a stepping stone to his famous studies on vitamins.

In Berlin, working with the great chemist, Abderhalden, Funk published many papers on protein chemistry and metabolism. Here Funk developed one of the first micro methods for estimating sugar and other substances in the blood, and familiarized himself with spectroscopy and the metabolism of uric acid, as well as malignant tumors.

In London between 1910 and 1915 Funk did research at the Lister Institute, synthesized an amino acid-like substance. Here he met Braddon, who first described to him in detail the dread beriberi. This launched Funk into one of his major achievements and led to the worldwide use of vitamins. Tests by Funk showed that beriberi was not an amino acid deficiency, but a lack of a "something" present in rice polishings.

Fascinating is the way Funk toiled week after week and month after month, developing polyneuritis in pigeons (comparable to beriberi in humans) by feeding them polished rice, administering rice polishings or ground yeast and watching the polyneuritis disappear. By assiduous fractionation he finally obtained fractions A and B, fed a polyneuritic pigeon fraction A and saw it dying, gave it fraction B and watched it recover. On he went subdividing fraction B, discarding non-effective fractions, subdividing again and again until, at last, he obtained a concentrated substance which proved to be thiamine or vitamin B₁, the anti-beriberi factor.

Funk then announced that more than one specific substance existed and was shortly proven right. He invented the name "vitamine" for such substances—"vita" indicating life, and "amine" for amine which he wrongly believed it to be. It was only after 30 years of bitter opposition that the word "vitamin" (the final "e" dropped) was adapted and became an important part of nutritional history.

In 1912 Dr. Funk projected his bold hypothesis which "laid the very foundation stone for the entire subject of vitamins." He proposed that there were at least four vitamins. His conclusions that such

diseases as beriberi, pellagra, rickets and scurvy were due to deficiency of specific chemical substances marked a milestone in medical science. A book on vitamins by Funk was translated into many languages.

Funk came to the United States shortly after the outbreak of World War I. With a collaborator he achieved a concentrated fraction of vitamins A and D, later marketed as Oscodal, the first vitamin product accepted by the A.M.A. Working with Dr. Louis Freedman, Funk devised methods still used today to measure bacterial growth in yeast.

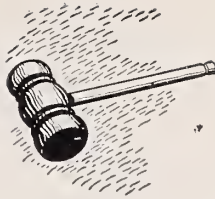
For many years Funk has been "occupied with the broad field of cancer and its possible treatment." In 1947 the Funk Foundation for Medical Research was set up. Here the Doctor has worked indefatigably in the cancer field. Yet he has found time to delve into prediabetic detection and new anti-ulcer therapy.

Over 150 scientific papers by Funk and collaborators have been published throughout the world and listed by Harrow. This shy, gentle, charming man, "who has always strived to work for the betterment of humanity" is, at 71, "at the height of his intellectual vigor."

Wolstenholme, G. E. W., O.B.E., M.A., A.B.L.S.; and Margaret P. Cameron, M.A., A.B.L.S. (Editors); *THE HUMAN ADRENAL CORTEX, CIBA FOUNDATION COLLOQUIA ON ENDOCRINOLOGY*, Vol. VIII, Little, Brown and Company, Boston, 1955, 665 pp., \$10.00.

This is the almost stenographic record of another of the now world-famous conferences held so frequently in London under the auspices of the Ciba Foundation. The size of the field is indicated by the fact that the conference had to be divided into two parts and by the fact that the proceedings run to 665 pages including the index. Nearly 70 participants made formal contributions, and all of the informal discussions are included, a particularly valuable feature. The first part, under the chairmanship of Gregory Pincus, contains 18 papers dealing principally with histological and biochemical aspects and cortico-medullary relationships; about half of them deal with the morphology of the adrenal cortex under various circumstances, while the remaining papers contain valuable accounts of aldosterone activity and of epinephrine-corticosteroid relationships. The second portion of the conference, George W. Thorn acting as chairman, contains the clinical studies. Once again aldosterone is fully discussed, the metabolic consequences of hypophysectomy or of adrenalectomy in man are described, Cushing's syndrome and the adrenogenital syndrome are brought up to date, and the importance of the hypothalamus in determining endocrine function is again stressed. Essentially this valuable book is an exciting preview of the medicine of tomorrow.

Thomas Findley, M.D.



president's page

NOW THAT WE HAVE DROPPED the robes of Cicero in our attacks on Catiline and taken on the armor of Saint George to fight the Hydra-head many sources of evils, I must myself take warning from the Apostle Paul, Romans, Chapter 12, Verse 21, "Be not overcome of evil, but overcome evil with good".

With evil divided into the unethical and the illegal, it seems to me that incorrect conduct, if illegal, is certainly unethical, but incorrect conduct may be of such nature that it is unethical but not necessarily illegal, and as a general rule when used in conjunction, the alternate conjunction is preferable to the coordinate. In fighting evil at the unethical or non-legal level one should start with one's self. In the June 1954 edition "Principles of Medical Ethics" of the AMA, Chapter VII, Section 2 gives my conscience the most concern in separating adequate service from immediate necessary care, and I can only say that at my age I am beginning to understand what the Red Queen meant when she said to Alice, "You have to run as fast as you can to stay in the same place"; to me the same place is reasonable care within that available in the community, that is certainly extended with the present day speed of transportation.

I am very happy that I can infer from Resolution 76, Page 936, *JAMA*, July 16, that the AMA is out of the accrediting business as far as hospitals are concerned. A resolution to withdraw from human accreditation might be in order to stop at the basic qualification for membership in the Association; that is, a graduate of a qualified medical school and duly licensed to practice under the laws of the states.

Now for our state Association, see Resolution 63, q.v. as above, Page 935, with a bow to the Medical Association of the State of Illinois. There seems to have been an intuitive reluctance on the part of the physicians of the Medical Association of Georgia to sign the Georgia Plan. Maybe even voluntary insurance places a person or corporate body between the physician and the patient. Then there is also our master policy enforceable at 51 per cent of membership. It occurs to me that if a patient is free to have a favorite physician, a physician should be free to have a favorite insurance agent. Insurance agents in Georgia are examined and duly licensed as men and women of knowledge and integrity and would perhaps appreciate our lending them some of the cloth of professional dignity.

The Master and the Servant relationship as the basic fibers of dignity is too complicated with paradoxes as the source of professional dignity to be gone into at this time.

H. D. Allen, Jr.

MAG Council Meeting

July 14, 1955, Atlanta, Ga.

AT A CALLED MEETING of the Council of the Medical Association of Georgia held in the Academy of Medicine, Atlanta, July 14, 1955, at 4:00 p. m. the following members were present: H. Dawson Allen, Milledgeville, President; Hal M. Davison, Atlanta, President-elect; R. C. McGahee, Augusta, First Vice-president; J. W. Chambers, LaGrange, Chairman of Council; Lee Howard, Savannah, First District; George Dillinger, Thomasville, Second District; W. G. Elliott, Cuthbert, Third District; Mark S. Dougherty, Jr., Atlanta, Fifth District; D. Lloyd Wood, Dalton, Seventh District; Neal F. Yeomans, Waycross, Eighth District; W. Bruce Schaefer, Toccoa, Ninth District; and H. L. Cheves, Union Point, Tenth District, councilors. Vice-councilors present were J. G. McDaniel, Atlanta, and Ralph Fowler, Marietta. Also present were Edgar Woody, Jr., *MAG Journal* Editor, and Mr. John Dunaway, Association Legal Counsel, and Messrs. Krueger and Kiser of the headquarters office.

The meeting was called to order at 4:10 p. m. by Dr. Chambers.

Dr. Chambers called on Mr. Krueger to give the invocation. The chairman then asked Mr. Krueger to read from the minutes of the Council Meeting of May 29, 1955; special Council meeting June 7, 1955; and the Executive Committee of Council meeting June 16, 1955, only in so far as they pertained to the Talmadge Memorial Hospital policy. Mr. Krueger also read from the minutes of the meeting of the Board of Regents held on June 8, 1955, relative to its original resolution of March 9, 1955, concerning the policies for the operation of the Eugene Talmadge Memorial Hospital.

Dr. Chambers reviewed the MAG-Talmadge Hospital policies. He presented in chronological order all the background data concerning this problem. Dr. Chambers emphasized that it is extremely important that all members consider the majority opinion as the Council policy. Whether or not as individuals they agree with this policy, all Council members have the responsibility of supporting the majority opinion on action taken at Council meetings.

Chairman Chambers read a communication from the Coweta County Medical Society received in the headquarters office on June 17, 1955, as follows: "The Coweta County Medical Society in regular meeting voted unanimously to condemn the action of the Board of Regents and to suggest that all doctors who participate in what we consider the illegal and unethical practice of medicine (vis. treatment of private patients for pay by full time physicians in competition to private physician) in the Eugene Talmadge Hospital be expelled from the Georgia Association and the operation of the hospital be declared by the Medical Association of Georgia unfit for medical training. We further feel that this is but an opening wedge to socialization and that unless stringent actions are taken now it will be too late to prevent further encroachment on our profession. Signed, Ben H. Jenkins, M.D., President, and

John G. Wells, M.D., Secretary, Coweta County Medical Society."

Dr. Chambers read a communication from the Richmond County Medical Society Board of Governors concerning action taken by them on July 11, 1955: "The Board of Governors of the Richmond County Medical Society met last night to consider what action should be taken by this society concerning a recent letter we received from Dr. H. D. Allen, Jr., President of the Medical Association of Georgia.

"It was the opinion of the Board of Governors that this matter should be referred to the Council of the Medical Association of Georgia.

"The letter in question will be brought to the Council Meeting by Dr. R. C. McGahee, First Vice-president of the Medical Association of Georgia. Very truly yours, J. L. Mulherin, M.D., Secretary-treasurer, Richmond County Medical Society."

Dr. Chambers then read the letter sent by H. Dawson Allen, President of the Medical Association of Georgia, to Clinton M. Templeton, President of the Richmond County Medical Society, dated July 5. In ensuing discussion it was declared that the letter expressed the personal opinion of Dr. Allen. The chairman advised that since this letter was then considered a personal communication it would not become part of the official minutes of the meeting but be considered by Council as a personal letter and be received for information only. Council members' remarks were then heard as the chairman called on each member of Council.

H. Dawson Allen stated that the Association should do nothing to impede the progress of the Medical College of Georgia, and Dr. Allen further questioned the present stand of the Association on a basis of the interpretation of both ethics and legality.

Hal M. Davison remarked that the House of Delegates and the Council had taken a stand and that there was no question in the MAG policy concerning the ethics of the matter—that the Regents' policies had already been declared unethical by the House of Delegates and the Council. Dr. Davison further stated that it is imperative the Association be concerned with the corporate practice of medicine wherever it occurs.

A statement from Peter B. Wright, Immediate Past-president, was then brought to the attention of Council. This statement is as follows: "I want all of you to know that my opinion regarding the Eugene Talmadge Memorial Hospital and policies has not changed one iota, and I do hope that the Medical Association of Georgia and its component county medical societies can take such a firm stand that a change of policy by the Board of Regents will result."

A statement from David Henry Poer, Secretary-treasurer, was then read. The statement was in effect that the Medical Association of Georgia should support the previous action of the House of Delegates and Richmond County Medical Society with all the resources of the organization; that to do otherwise would be a failure to carry out the specific directives of the members of the Medical Association of Georgia.

R. C. McGahee, First Vice-president, then remarked that there perhaps are some legal matters still to be clarified but that the main issue is one of ethics. Dr. McGahee suggested the following items for the consideration of Council: (1) to keep all the members of the Medical Association of Georgia informed of any action

or any incident or any communications concerning the operational policies of the Talmadge Memorial Hospital, and (2) to obtain better relations with the press on this matter. He suggested that either the *Journal* Editorial Board or the Public Relations Committee of the Association strive to present the viewpoint of the Association as it concerns the operational policies of the Eugene Talmadge Memorial Hospital. He further emphasized that the public must also be well informed of the Association's stand and the resultant action. Dr. McGahee presented a statement to the Council concerning the activity and the dignity with which his committee (Special MAG Talmadge Hospital Committee appointed by the president of the Association with the approval of the Council of the Medical Association on request of the House of Delegates) had proceeded on the instructions of the Council in their liaison with the Board of Regents' Education Committee.

Lee Howard, First District Councilor, remarked that it appeared to him that the Council should either cease all activity with regard to the operational policies of the Talmadge Memorial Hospital or should strive to implement the stand taken by the Association.

George Dillinger, Second District Councilor, brought to the attention of Council that Thomas County Medical Society was unanimous in its action in support of House of Delegates and Council policy to date on the matter of the operational policies of the Eugene Talmadge Memorial Hospital.

W. G. Elliott, Third District Councilor, advised that work with the Legislature in Georgia be planned and that the Association's stand on this matter be reiterated.

Mark S. Dougherty, Jr., Fifth District Councilor, stated that the Association has assured Richmond County Medical Society of support and that Richmond County Medical Society must initiate any further action on the matter. He felt that it was Council's task to mobilize the opinion in the state against the Regents' operational policies, if need be to delve into the legality of these policies, and perhaps to consider the advisability of bringing a test case into the courts of Georgia.

D. Lloyd Wood, Seventh District Councilor, said that the Regents' operational policies of the Talmadge Hospital are a threat to the private practice of medicine, the beginning of the socialization of medicine. He stated that it was his opinion that the physicians in the Seventh District are unanimously opposed to the Regents' policy of allowing pay-patients to enter the Talmadge Memorial Hospital. Neal F. Yeomans, Eighth District Councilor, remarked on the unfortunate press relations given the Association on this matter. He further stated that Council should be concerned with all hospitals and not just the Talmadge Memorial Hospital on this matter. He believes that the Association and its policy had hurt the Medical College of Georgia, and he recommended that the Council appoint a new committee to work with the Medical College of Georgia and investigate hospitals over the state to see if they are ethical.

W. Bruce Schaefer, Ninth District Councilor, remarked that in his opinion it is imperative that the members of Council not foster their own private opinions on this matter but express the opinion of the majority of Council as Council votes.

Dr. Chambers then asked for further remarks on the matter, and as there were none he called for a general discussion.

On motion (Dillinger-Howard) the following resolution was presented to the Council:

"Resolution of Council in session July 14, 1955, for the guidance of the Richmond County Medical Society.

"By repeated action of the House of Delegates of the Medical Association of Georgia and repeated action of Council it has been stated that the present Regents' approved plan of operation for the Eugene Talmadge Memorial Hospital is illegal and unethical. The Council today reiterates this action and further states that physicians referring patients to that institution would be guilty of fostering unethical practices.

"Further, the Council will appropriate funds to assist Richmond County Medical Society if any legal defense becomes necessary."

This motion was discussed and a substitute motion was offered by Lloyd Wood and seconded by H. Dawson Allen. The Wood motion reads as follows:

"The Council reaffirms the action of the House of Delegates and the previous Council action, and the Council is opposed to the corporate practice of medicine anywhere in the State of Georgia, not only in the Talmadge Memorial Hospital, but if the corporate practice of medicine is being carried out by any hospital, the Council is similarly opposed to it and certainly in no way condones it."

After discussion the question was called, and the Wood motion passed unanimously.

Dr. Dillinger then introduced another motion which reads as follows:

"Be it resolved, that the Chairman of Council be empowered to employ an outstanding legal firm to answer the following questions after consulting the Association attorney. Also be it resolved, that the Council approve an appropriation of the necessary funds for this action and request the Association's Audit and Appropriations Committee to make these funds available.

"1. Is it legal for an agency of the State of Georgia to enter the practice of general medicine and surgery in direct competition with the Georgia physicians as outlined in the Regents' plan of operation of the Eugene Talmadge Memorial Hospital?

"2. Would the Regents' plan of operation of the Eugene Talmadge Memorial Hospital set a legal precedent that would enable other Georgia hospitals to set up similar programs of operation?

"3. Is it legally possible for the Medical Association of Georgia to bring an injunction against the Board of Regents of the University System to enjoin the State of Georgia from entering the general practice of medicine?"

After discussion this motion was passed unanimously.

Chairman Chambers then called for other business pertinent to the Talmadge Hospital policy.

Edgar Woody, Jr., Editor of the *Journal of the Medical Association of Georgia*, then asked the members of Council for their opinions on effecting better news releases on all matters of Association policy. It was recommended that the Publications Committee and the Public Relations Committee be consulted on the matter of news releases, which need not be delayed until the actual *Journal* publication time. After approval by these committees the releases on Association policy and planning might be given directly to the newspapers.

There being no further business, the meeting was adjourned at 6:45 p. m.

Journal Editorial Board Meeting

July 17, 1955, Atlanta, Ga.

A MEETING OF THE EDITORIAL BOARD of the *Journal of the Medical Association of Georgia* was held at 11:30 a. m., Sunday, July 17, 1955, at the Academy of Medicine, Atlanta. Present were the following: Edgar Woody, Jr., Editor; Miss Frances H. Porcher, Managing Editor; Ted F. Leigh, Photography Editor; Herbert S. Alden, Thomas Findley, Arthur M. Knight, Jr., Lester Rumble, Jr., and Patrick C. Shea, Jr., Contributing Editors; and Hal M. Davison of the Publications Committee.

The meeting was called to order by Dr. Woody. The first topic for discussion was editorial contributions: the reasonable number each contributing editor would be expected to contribute to the *Journal*, and the possibility of having each one be responsible for soliciting editorials from others. It was the consensus of opinion that each contributing editor should write two editorials a year and that they should be assigned to meet a specific deadline. The choice of subject of each editorial is to be left to the writer except in certain instances. The editor should solicit special editorials on current developments from the people most closely connected with such developments. In the case of any solicited editorial, the author should be made fully cognizant of the fact that the request does not carry with it any assurance that it will be accepted by the editorial board.

In connection with the discussion of accepting or rejecting contributions for publication, Dr. Woody showed the board the form letters now used to inform contributors of the status of their articles. The physicians present approved the use of the mimeographed form for acceptance, but agreed that the editor should write a letter to inform a contributor that his paper has been found unacceptable for publication by the Editorial Board.

Form letters used in connection with getting books reviewed were also passed around. Since the system was inaugurated nine months ago, book reviews have increased approximately 500 per cent. There were 34 published book reviews in the past nine months and seven reviews in the nine months immediately preceding that period. Dr. Woody asked the members present to suggest names of doctors who would be interested in reviewing books or giving editorial comment on specific subjects.

Topics for non-scientific editorials were suggested by board members—medical ethics, doctor-to-doctor relationships, public relations (it was suggested that hypothetical cases be used to illustrate points rather than writing dry essays), specialty examining boards, impact of union health services (WHO and the UN) on the medical profession, charity facilities in the state, and the physician from the layman's point of view.

On the subject of format the following items were brought up: (1) physicians placement page—feeling is that the publication of available physicians is a total

waste of space; (2) editorials—some members thought the editorial section should be in a more prominent place, but all agreed that they should be in the same position in every issue.

Dr. Knight suggested that a new department of the *Journal* be set up consisting of particularly interesting cases with different authorities giving a short discussion of each case. It is felt that many doctors have had and will have one or two outstanding cases that would be of interest to other doctors in the state—but they hesitate to write scientific articles based on a "series" of one case. The first of these cases with discussion will appear in the October issue.

After a discussion of better press relations for the Medical Association of Georgia, the meeting was adjourned at 1:00 p. m.

Third District PR Conference

August 11, 1955, Americus, Ga.

AT THE THIRD DISTRICT Presidents' and Secretaries' Conference held August 11, 1955, at the Americus and Sumter County Hospital, Americus, the following county medical societies were represented: *Muscogee*; James A. Elkins, President, and Robert H. Vaughan, Secretary. *Ocmulgee*; William R. Baker, President, and William E. Coleman, Secretary. *Flint*; C. E. McArthur, President, and Perry Busbee, Secretary. *Sumter*; Bon M. Durham, President, and Russell Thomas, Secretary. *Macon*; J. Fred Adams, President. *Peach Belt*; A. S. Marshall, President. *Ben Hill-Irwin*; Ralph D. Roberts, President. *Third District Medical Society*; J. L. Stapleton, President, and T. Schley Gatewood, Secretary.

County medical societies not represented were: Randolph-Terrell and Taylor.

After dinner served at the Americus and Sumter County Hospital, the meeting was called to order by Chris McLoughlin, Chairman of the MAG Public Relations Committee. Dr. McLoughlin explained that the Public Relations Committee was sponsoring this meeting and that similar meetings were in progress for the county society officers for each district in the state.

Hal M. Davison, MAG President-elect, keynoted the conference with a brief talk about the importance of the county medical society.

Bon M. Durham, Sumter County Medical Society President, greeted the conference as local society host for the meeting.

Mr. John F. Kiser, MAG Assistant Executive Secretary, and Mr. Milton D. Krueger, MAG Executive Secretary, gave short presentations on the role of the county medical society and the Medical Association of Georgia.

Dr. McLoughlin presented a brief speech on "Medicine in the Public Eye."

After a general discussion of problems facing the county medical societies, each society was presented with an official minutes book for use at society meetings. Booklets were also distributed showing how to improve medical society activity.

LAST CALL FOR SCIENTIFIC PAPERS — 106th ANNUAL SESSION

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ANNOUNCEMENTS

Georgia Diabetes Association Meeting—Academy of Medicine, Atlanta, September 18, 1955, at 2:00 p.m. A scientific program will be presented. All physicians interested in furthering the study and care of diabetes in Georgia are urged to attend.

Georgia Heart Association—Seventh Annual Meeting and Scientific Session—General Oglethorpe Hotel, Savannah, September 23 and 24, 1955. Registration free to all physicians, interns, and medical students, and the scientific session is approved by the GAGP as formal postgraduate training. Speakers include the following: William T. Foley, Cornell; Bernard Lown, Boston; Harry Gold, Cornell; Arthur Master, Mount Sinai Hospital, New York; and Gene H. Stollerman, Northwestern. For further information, contact the Georgia Heart Association, Western Union Building, Atlanta.

Institute of Industrial Health of the Univ. of Cincinnati Postgraduate Course on "Modern Considerations and Methods in Handling the Lead Problems in Industry"—Kettering Laboratory, Cincinnati, November 7-11, 1955. General discussion and round table discussions will be offered. Physicians and industrial hygienists who are concerned with the lead problem and are interested in attending the course should write to the Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

Venereal Disease 24th Postgraduate Course—University of Chicago, September 26-30, 1955. Course is designed to acquaint the practitioner with the latest developments in diagnosis, treatment, and management of venereal diseases. No fee. Apply to the Section of Dermatology, Dept. of Medicine, University of Chicago, Chicago 37, Ill. Course accredited by the AAGP.

Georgia Psychiatric Association Fall Meeting—Academy of Medicine, Atlanta, September 19, 1955. Organized in May 1955, the group has as its president J. R. Shannon Mays, Macon; Joseph S. Skobba, Atlanta, is president-elect; and Thomas M. Hall, Macon, is secretary-treasurer. Approximately 30 psychiatrists in Georgia belong to the organization. The association has applied for district branch status with the American Psychiatric Association. Trustees are as follows: Carl A. Whitaker, Atlanta; James N. Brawner, Jr., Smyrna; Y. H. Yarbrough, Milledgeville; Charles R. Smith, Columbus; Joseph D. McElroy, Atlanta; and Z. Sweeney Sikes, Jr., Dublin.

DEATHS

WILLIAM CULLEN MCCARVER, Vidette, died July 24, 1955, in an Augusta hospital after an extended illness. Dr. McCarver was 72 at the time of his death.

A native of Fayette, Alabama, he came to Vidette many years ago to practice medicine. He was a member of the Burke County Medical Society, Southern Medical Association, Waynesboro Masonic Lodge, the Shrine, and the Vidette Methodist Church.

Survivors include his wife, the former Miss Commie Gay; two sons William C. McCarver, Jr., Gainesville,

and The Reverend Clyde Gay McCarver, of North Carolina; and four grandchildren.

Funeral services were conducted on July 25th at the Vidette Methodist Church; burial was in Rose Dhu Cemetery. Members of the Burke County Medical Society were honorary pallbearers.

WILLIAM H. TRIMBLE, Atlanta, died July 26, 1955, at his home, 376 Manor Ridge Drive, N. W. He was 52 years of age.

Dr. Trimble was born in Hogansville and received his education at Emory University, Vanderbilt University, and the University of Pennsylvania. During World War II he served in Africa, Italy, and France with the 43rd General Hospital Unit. He was a member of the Fulton County Medical Society, the American College of Physicians, Phi Delta Theta, social fraternity, and Alpha Kappa Kappa, medical fraternity. He belonged to the St. Mark Methodist Church in Atlanta.

Funeral services were held on July 27, 1955, at Spring Hill; burial was in Westview Cemetery.

Surviving are his wife, the former Miss Grace Fincher; a son, Mr. William H. Trimble, Jr.; two daughters, the Misses Ann and Grace Trimble, all of Atlanta; and his parents, Mr. and Mrs. W. A. Trimble, Hogansville.

SOCIETIES

The EIGHTH DISTRICT MEDICAL SOCIETY and WARE COUNTY MEDICAL SOCIETY met on August 11th at the country place of G. W. Barker, St. Marys. At this meeting, business was dispensed with except for a short talk by Mr. John F. Kiser of the headquarters office; the activities of the day included barbecue, golf and swimming. Joint hosts with Dr. Barker were Paul Christian, St. Marys; R. R. McCollum, Kingsland; and J. O. Simmons, Woodbine.

The August meeting of the BIBB COUNTY MEDICAL SOCIETY was held at 8:00 P. M. on August 2nd in the Kilowatt Room, Macon. Tom Ross, Jr., president, presided at the meeting. The program was devoted to a discussion of the Columbus Blue Cross and Blue Shield plans by Luther Wolfe, president of the company, and Mr. John Galloway, professional relations director. The society went on record as endorsing the Columbus Plan and took steps to put the plan in operation in Macon. Herbert Olnick, Chairman of the Bibb County Medical Society Insurance Committee, discussed the Blue Cross and Blue Shield plans and also explained the MAG professional liability insurance plan. Mr. John Kiser, of the MAG headquarters office, discussed state legislation matters and reported on the activities of the headquarters office.

FULTON COUNTY MEDICAL SOCIETY met on August 4, 1955, at the Academy of Medicine, Atlanta. At this regular monthly meeting, Mr. Boisfeullet Jones, vice-president and administrator of health services at Emory University, was the speaker. Mr. Jones told the members that the operation of the Emory University Clinic is essential to continuance of Emory's medical school. Mr. Jones felt that the criticism that the operation of the clinic constitutes the corporate practice of medicine was entirely unjustified. He and R. Hugh Wood, dean of the medical school, issued an invitation to the Fulton County Medical Society and the MAG to send commit-

tees to visit the school if they wish to see how the school and the clinic are run.

The GRADY COUNTY MEDICAL SOCIETY met on July 12, 1955, at the Grady County Hospital in Cairo. Officers for the year were elected at this meeting, they are as follows: C. K. Singleton, Cairo, president; and John A. Ferrence, Whigham, secretary-treasurer.

Members of the MUSCOGEE COUNTY MEDICAL SOCIETY have endorsed the fluoridation of Columbus' water supply, and with their July statements most of the Columbus physicians sent fluoridation appeals to their patients. The statement is as follows: "I would like to take this opportunity to tell you that I approve the fluoridation of the water supply for Columbus. It has been proven that this health measure can do no possible harm to anyone. It will help our growing children develop hard teeth, and so help prevent dental decay."

The organizational meeting of the new PEACH BELT MEDICAL SOCIETY was held at 7:30 P. M. on July 19th at the Peach County Hospital at Ft. Valley. Members of the society are A. S. Marshall, president; E. Faxton Seay, secretary; H. E. Weems, delegate; and Daniel Nathan, A. G. Hendricks, Jacob E. Haslam, A. B. Waddell, W. G. Talbert, V. W. McEver, and M. V. Anders. The members of the Society are from Fort Valley, Perry, Warner Robins and Roberta.

It was decided that the organization will meet every month at the Fort Valley hospital until organized. The matter of maintaining associate membership in Bibb County Medical Society was discussed. The organization was started due to the absence in the area of a local medical society.

On September 29, 1955, the WILKES COUNTY MEDICAL SOCIETY will celebrate its fiftieth anniversary. The charter was granted to the society on September 29, 1905. The meeting will take place at the Washington Country Club; Harry Harper, Augusta, will present the scientific program. Special guests who will also address the meeting are H. Dawson Allen, Jr., and David Henry Poer. A golf tournament and barbecue will complete the celebration. One of the charter members of the society, A. W. SIMPSON, SR., still active in the practice of medicine, will be present at this meeting.

PERSONALS

First District

THOMAS C. DICKERSON, Soperton, Mrs. Dickerson, and their daughter, Ansley, have moved into a new home on Mt. Vernon Road in Soperton. Dr. Dickerson opened his office for the practice of general medicine on July 13, 1955. He is a graduate of Emory University School of Medicine, and he interned at Grady Memorial Hospital in Atlanta. Dr. Dickerson is a member of Sigma Chi, social fraternity; Phi Chi, medical fraternity; and Alpha Omega Alpha, honorary medical fraternity. Mrs. Dickerson is the former Miss Ann Brockman of Atlanta.

D. B. EDWARDS, Ellabelle, has returned to his practice after undergoing surgery in Savannah. Dr. Edwards spent several weeks in Savannah convalescing from the operation and returned to his home in Ellabelle the latter part of July.

DAVID A. MCGOLDRICK, Savannah, has been named to serve on the Chatham County Board of Education. Dr. McGoldrick will fill an unexpired term ending December 31, 1957. A native of Brooklyn, N. Y., Dr. McGoldrick studied medicine at Harvard University and interned at Bellevue Hospital in New York City.

The six Savannah physicians participating in the prenatal clinic at St. Joseph's Hospital presented the hospital with a full scholarship for a student nurse for the three year term. The presentation was made by M. M. SCHNEIDER, D. L. BRAWNER, JOHN H. ANGELL, C. E. SAX, L. S. BODZINER, and ALBERT J. KELLEY.

H. L. SCHOFIELD, JR., a native of Florida, is now associated with LEE HOWARD, SR., and LEE HOWARD, JR., Savannah, in the Howard Clinical Laboratory in the practice of pathology. Dr. Schofield for the past two years has been acting clinical pathologist of the Orangeburg Regional Hospital, Orangeburg, S. C. Dr. Schofield received his M.D. degree from the Medical College of South Carolina; he interned for one year in the Orange Memorial Hospital, Orlando, Fla. He then returned to the Medical College of South Carolina and has spent the past four years in the department of pathology as a teaching fellow, becoming board eligible in pathological anatomy and clinical pathology. Dr. and Mrs. Schofield are living at 1131 East 51st Street, Savannah.

Second District

L. Richard Lanier, Jr., announces the opening of his offices for the practice of obstetrics and gynecology at Doctors Center, 1009 North Monroe Street, Albany, Georgia.

FRANK THOMAS, Albany, spoke at a recent meeting of the Albany Chapter of the Association for the Help of Retarded Children. Dr. Thomas' topic was "The Cerebral Palsies". His talk was followed by a question and answer period.

Third District

No news received.

Fourth District

C. R. BARKSDALE, JR., formerly of Grantville, has moved his office to Hogansville. There he will take over the office of EDWIN MOLYNEAUX who has moved recently to LaGrange. Dr. and Mrs. Barksdale will continue to live in Grantville for the present.

The new clinic of R. M. PATY, JORDAN CALLAWAY, and JAMES W. PURCELL, Covington, was opened on July 5, 1955. Located on Tate Street, the 17 room clinic is a modern brick structure, air conditioned, and equipped with the latest in laboratory and x-ray equipment. Each doctor has a consultation office and two examining rooms. Dr. Purcell joined the staff on July 6th, and he is now residing with his wife and their three year old daughter, Gayle, at 218 King Street. He is a graduate of the Medical College of Georgia and has had four years of postgraduate training in surgery at Georgia Baptist Hospital, Atlanta.

W. P. SMITH, Bowdon, recently celebrated his 89th birthday with a family dinner at his home. On this occasion he was written up in the *Bowdon Bulletin* and the *Atlanta Constitution*. Dr. Smith received his M.D. degree from the Medical College of Georgia in 1891 and

rode his horse home to Troup County to begin practicing medicine. For 64 years, Dr. Smith has been answering the call of all who needed him, and he plans to continue his practice until he is 100.

Fifth District

HARRY J. CRIDER, JR., Atlanta, announces the opening of his office for the practice of obstetrics and gynecology. His office will be located at 1857 Cheshire Bridge Road, N. E. (the Buford Highway) temporarily; he will move into his permanent offices at 3133 Maple Drive, N. E., on January 1, 1956.

ROGER W. DICKSON, Atlanta, addressed the Pilot Club of Atlanta at the Atlanta Woman's Club on July 20, 1955. The subject of his talk was "Retarded Children."

JAMES K. FANCHER, Atlanta, and Mrs. Fancher left on August 19th for Europe. They will spend six weeks traveling in England and France and attending medical meetings in Vienna, Austria, and Genoa, Italy. They plan to return on the 29th or 30th of September.

JAMES LANGFORD and his family have recently moved to Roswell for Dr. Langford to practice medicine in association with JOHN H. HINES at the Hines Clinic.

Sixth District

RICHARD L. HANBERRY, Macon, has opened his office at 2106 Ingleside Avenue, in Macon, for the practice of obstetrics and gynecology. Dr. Hanberry, a native of Macon, is a graduate of Mercer University and the Medical College of Georgia. He interned at Charity Hospital in New Orleans and spent three years in obstetrics and gynecology at Grady Memorial Hospital. Dr. Hanberry is a member of the Kappa Alpha Order, social fraternity; Blue Key, national honor fraternity; and Phi Rho Sigma, medical fraternity.

MALCOLM R. HODGES, Macon, has opened offices for the practice of general medicine at 563 Walnut Street, Macon. Born in Oconee in Washington County, Dr. Hodges has also lived in Sandersville. He is a graduate of Mercer University and Tulane University School of Medicine. Dr. Hodges comes to Macon after one year of interning in the McLeod Infirmary, Florence, S. C.

Seventh District

H. L. ERWIN, Dalton, has recently moved his office to his home, 203 Cleveland Street. He formerly practiced in the office with TRAMMELL STARR in the building adjacent to the hospital. Dr. Erwin has practiced medicine for 51 years.

W. L. FLESCH, Waycross, has recently established private offices at 505 Pendleton, the former Ware Conservatory, in Waycross. Dr. Flesch, a urologist, is a native of New York, and prior to coming to Waycross he served in the U. S. Navy in Texas and in Korean waters during the recent Korean War. He is a member of the Ware County Medical Society, the American Urological Association, and the 38th Parallel Medical Society of Korea. He is also a member of Grace Episcopal Church and the Okefenokee Golf Club of Waycross.

Eighth District

At the annual convocation of the American College

of Chest Physicians held in Atlantic City on June 4th JOSEPH A. LEAPHART, Jesup, received his fellowship certificate. He was one of the 251 members from 42 states, the District of Columbia, five provinces of Canada, Brazil, India, Korea, and the Philippines to whom certificates of fellowship were awarded.

Announcement has been made of the marriage on September 4, 1955, of Miss Frances LeVerne Garbutt of Valdosta to JAMES SIDNEY MAUGHON, Valdosta. Dr. Maughon is a graduate of the University of Virginia and the Medical College of Georgia, where he was a member of Alpha Kappa Kappa, medical fraternity. He interned at the U. S. Naval Hospital in Jacksonville, Fla., and later served in naval hospitals in Japan and Charleston, S. C. He received two years' residency training in surgery at Grady Memorial Hospital, Atlanta.

THOMAS H. MOSELEY, a native of Virginia, has opened offices in Valdosta for the practice of obstetrics and gynecology. He received his B.S. degree from Randolph-Macon Men's College, Ashland, Va., and his M.D. degree from the Medical College of Virginia. Dr. Moseley interned at Brooke Army Hospital in San Antonio, Texas. He served in the U. S. Army Medical Corps in World War II and in the Korean War, and has just recently been discharged from the Army. Dr. Moseley's office is located at 1306 North Patterson Street, Little-Griffin Hospital Building, in Valdosta.

O. R. WILSON, Alma, has begun the practice of medicine in Alma with W. W. SHARP. Dr. Wilson arrived in Alma on July 1st and resides with Mrs. Wilson and their two children at 602 East 20th Street. Dr. Wilson, a native of Galax, Va., is a graduate of the University of Virginia Medical School; he interned at the Richmond (Virginia) Hospital and completed residency training at the University Hospital in Augusta.

J. W. SIMMONS, Brunswick, recently broke three ribs in a fall at his home. Dr. Simmons had been recovering from a long illness when the accident occurred. We hope by now that he is well on the road to recovery.

FRED C. SMITH, a native of Cedartown, has opened offices in Valdosta for the practice of general surgery. Dr. Smith received his B.S. degree from Emory University and his M.D. degree from Emory University School of Medicine. He served his internship at Grady Memorial Hospital and his residency in general surgery at the VA Hospital in Atlanta. For a year he was a fellow and instructor in surgery at Emory University Hospital and was also associated with J. D. MARTIN, JR., there. Dr. Smith's office is located at 1306 North Patterson Street, Little-Griffin Hospital Building. He and his family live at 2106 Azalea Road.

Ninth District

RICHARD F. GRAVES, from Clarkesville, has moved to Winder where he is engaged in the practice of general medicine. Dr. Graves has been interning for the past year at St. Mary's Hospital in Athens. A graduate of the University of Georgia, he received his M.D. degree from the Medical College of Georgia in 1954. He is a member of Pi Kappa Phi, social fraternity; Phi Eta Sigma, honorary scholastic fraternity, and Theta Kappa Phi, medical fraternity. Dr. and Mrs. Graves and their son are living at 111 Alexander Street, Winder.

A feature article recently appeared in the *Atlanta Constitution* which told of the work that VIRGINIA HAMILTON MALEY, Gainesville, is doing with the Hall County Health Office. Dr. Maley, public health officer for Hall County for the past five years, gave up general medical practice to become one of two women health officers in Georgia. Most of the field work of the office is done by nurses; Dr. Maley's work is to a large extent administrative.

JOHN W. MAULDIN, Lawrenceville, has been reelected chairman of the State Medical Education Board in Georgia. This board administers educational scholarships to medical schools for qualified applicants who agree to practice up to five years in rural communities in Georgia when they become doctors. The program was established in 1953.

WILLIAM GORDON MORROW, a native of Hahira, has joined the staff of the Hall County Hospital as anesthesiologist. Dr. Morrow is a graduate of Emory University and the University of Maryland School of Medicine. He took special training in anesthesiology at the Lahey Clinic, Boston, and at the National Naval Medical Center, Bethesda, Md.

WILLIAM PERRIN NICOLSON, III, formerly of Atlanta, has recently become associated with RAFE BANKS, JR., Gainesville, in the practice of urology. A graduate of Washington and Lee University, Lexington, Va., Dr. Nicolson received his M.D. degree from the Medical College of Georgia in 1946. He interned at Cook County Hospital, Chicago, and had one year of residence at the University Hospital in Augusta before going to Grady Memorial Hospital in Atlanta where he was resident in pathology. He served two years in the U. S. Navy and returned to Grady to complete three years' residency in urology. Dr. and Mrs. Nicolson, the former Miss Betty Barnes of Valdosta, have two children, William Perrin IV and Elizabeth Tuller. They live at 1657 Riverside Drive.

GEORGE ROBERT PARKERSON, Winder, has opened offices in Winder for the practice of general medicine and surgery. His offices are located on Jackson Street. A graduate of Duke University and Duke Medical School, Dr. Parkerson comes to Winder from Grady Memorial Hospital in Atlanta where he was assistant resident in surgery and studied obstetrics, gynecology, and pediatrics. He is a member of Phi Beta Kappa, national scholastic fraternity; Alpha Omega Alpha, national honorary medical fraternity; Omega Delta Kappa, leadership fraternity; Phi Chi, medical fraternity; and Sigma Alpha Epsilon, social fraternity.

REUBEN E. SMITH, a native of Lawrenceville, has returned to his home town to practice medicine. He is associated with F. A. SIMS, JR., on Crogan Street. Dr. Smith is a graduate of Vanderbilt University and received his M.D. degree from the Medical College of Georgia. After service with the Marine Corps he studied pediatrics and internal medicine at Macon (Georgia) Hospital and practiced in Lawrenceville for a year and a half before moving his practice to Buford for six years. Last year he spent studying cardiology at Emory University.

On July 17, 1955, Gilmer County citizens turned out

by the hundreds for the dedication of the new Watkins Memorial Hospital, financed by Hill-Burton funds, a bond issue, and a \$50,000 donation from 79-year-old EDWARD WATKINS. Former Governor Herman Talmadge made the dedicatory address and paid tribute to the venerable doctor who launched the move to get a hospital in the county with his personal check for \$50,000. The hospital is named for Dr. Watkins' uncle and father who also practiced in Gilmer County. Staff members of the new hospital include, besides Dr. Watkins, JAMES BURDINE, C. B. WATKINS, JR., and C. B. TEAL.

Tenth District

The director of the state crime laboratory has appointed seven Augusta physicians as medical examiners for Richmond County. The seven include A. W. BAILEY, D. MARION SILVER, E. V. HASTINGS, L. D. STODDARD, A. B. CHANDLER, D. F. MULLINS, JR., and EDGAR R. PUND.

ALVA H. FAULKNER, Augusta, announces the removal of her office to the Medical Arts Building, 1467 Harper Street.

SEYMOUR FRIEDMAN, Augusta, announces the removal of his offices to 1132 Druid Park Avenue; his practice is limited to urology.

F. N. HARRISON, Augusta, announces the removal of his office from 407 Seventh Street to 1136 Druid Park Avenue.

ROBERT C. MCGAHEE, Augusta, has been named president of the medical staff of University Hospital. Other staff officers named at the same meeting are GEORGE B. WRIGHT, vice-president; POMEROY NICHOLS, secretary; and VICTOR ROULE, member of the credentials committee.

ALEX T. MURPHEY, Augusta, announces the removal of his office to 1132 Druid Park Avenue, with practice limited to internal medicine.

CHARLES H. RICHARDSON, JR., JERRY P. WOODHALL, and CALDER B. CLAY, JR., Macon, announce their association in the practice of general and thoracic surgery. Their new offices are located at 724 Hemlock Street in Macon.

In a recent issue of the *Washington News Reporter* there appeared a feature article about ROBERT GRIER STEPHENS, *Washington*. Dr. Stephens has twice served as president of the Wilkes County Medical Society and six times as secretary and treasurer. Born in Crawfordville, Dr. Stephens moved with his family to Washington in 1881. He was educated in Washington and Atlanta; he graduated from the University of Georgia in Athens in 1902. He graduated from the Atlanta College of Physicians and Surgeons in 1905. Winning the appointment of resident physician of the Wesley Memorial Hospital in Atlanta, he opened the doors and registered the first patient in that institution, now Emory University Hospital. In 1907 Dr. Stephens began the general practice of medicine in Atlanta where he remained until 1939 when he returned to Washington to practice.

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Biographical data forms have been mailed to all Medical Association of Georgia members to facilitate MAG Headquarters office files.

Please fill this form out in duplicate; send the original (white copy) to your County Medical Society Secretary; and send the duplicate (yellow copy) to the Medical Association of Georgia, 875 W. Peachtree, N. E., Atlanta, Ga.

These biographical forms are maintained solely for your benefit. Return them at once as requested in your own interests.

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Milton D. Krueger
Executive Secretary

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5. A sign identifying the exhibit and its authors (as shown above) will be furnished by the Medical Association of Georgia.

Fifteen Year Follow-up of an Intestinal Shunt Without Relief of the Primary Obstruction

THOMAS H. WILLIAMS, M.D., and HERBERT M. OLNICK, M.D., Macon, Ga.

IN FORMER YEARS, entero-enterostomy was occasionally employed as a palliative procedure in the treatment of intestinal obstruction. If the obstruction resolved itself, the entero-enterostomy was curative. If, however, the obstruction persisted, a blind segment remained which could dilate and form a large pouch. More recently, better pre-operative management and supportive therapy have enabled the surgeon to initially extirpate the cause of the obstruction in most cases.

A recent case which we encountered was of special interest because of 15 year duration of symptoms and because of the characteristic x-ray findings which afforded an accurate pre-operative diagnosis.

Mrs. C. is a 45 year old white woman who was admitted to the Parkview Hospital in September 1954. Her chief complaints were abdominal cramps of four days duration, nausea, vomiting, and constipation of two days duration. Her present illness dated back to 1929 when a bilateral salpingo-oophorectomy was done for tubo-ovarian abscesses. Two years later, in 1931, a ruptured appendix was removed.

Eighteen years before the present admission, the first of four operations for intestinal obstruction was performed. Three years later, the remaining three operations were done within a six day period of a single hospital admission. The final operation included a lateral anastomosis to by-pass the obstructed loop.

Since 1939, the patient has had from two to 12 loose stools daily. It was not unusual for her to have three or four bowel movements during the night. This diarrhea has been interrupted by increasingly frequent episodes of acute intestinal obstruction. The patient has remained in a chronic state of malnutrition and anemia for which she required numerous transfusions. At one point, her weight dropped to 80 pounds. She has spent the

major portion of the past six months in the hospital.

On this admission, physical examination revealed a thin, dehydrated, chronically ill white female. Marked abdominal distention and visible hyperperistalsis were noted.

The laboratory data indicated marked chloride deficiency and a low serum protein, as well as a normochromic, normocytic anemia.



Figure 1

Scout film revealing tremendously dilated jejunal loops. The fluid-filled pouch appears as a soft tissue mass in the left side of the pelvis.



Figure 2

Small intestinal series. One hour film shows barium entering dilated jejunum.



Figure 3

Small intestinal series. Eight hour film shows barium dispersed throughout the dilated small bowel.

A flat plate of the abdomen on admission revealed extensive distention of two loops of small bowel. These loops were located in the mid-abdomen and extended down into the pelvis. (Figure 1)

A motility series performed in another hospital earlier this year revealed a large dilated loop of small bowel which retained the barium meal after all the other opaque media had passed into the colon. The interpretation was a pouch-like structure or a blind loop. (Figures 2, 3, 4)

After adequate preoperative preparation, abdominal exploration was performed. Operative findings confirmed the presence of a blind bilobulated pouch 12 cm. in its greatest diameter. It lay distal to a large functioning lateral entero-enterostomy. (Figure 5) The pouch and adjacent loops were resected, and an end-to-end anastomosis was performed. Upon dissecting the specimen, there was noted in the wall of the pouch a second smaller stoma which opened into a short segment of ileum densely bound and obstructed by adhesions. This ileal segment could be traced back to the lateral entero-enterostomy to complete the loop. Numerous superficial mucosal ulcerations were noted throughout the pouch.

The patient made an uneventful recovery. It has



Figure 4

Small intestinal series. Twenty-four hour film shows the barium retained in the pouch after most of the opaque media is in the colon.

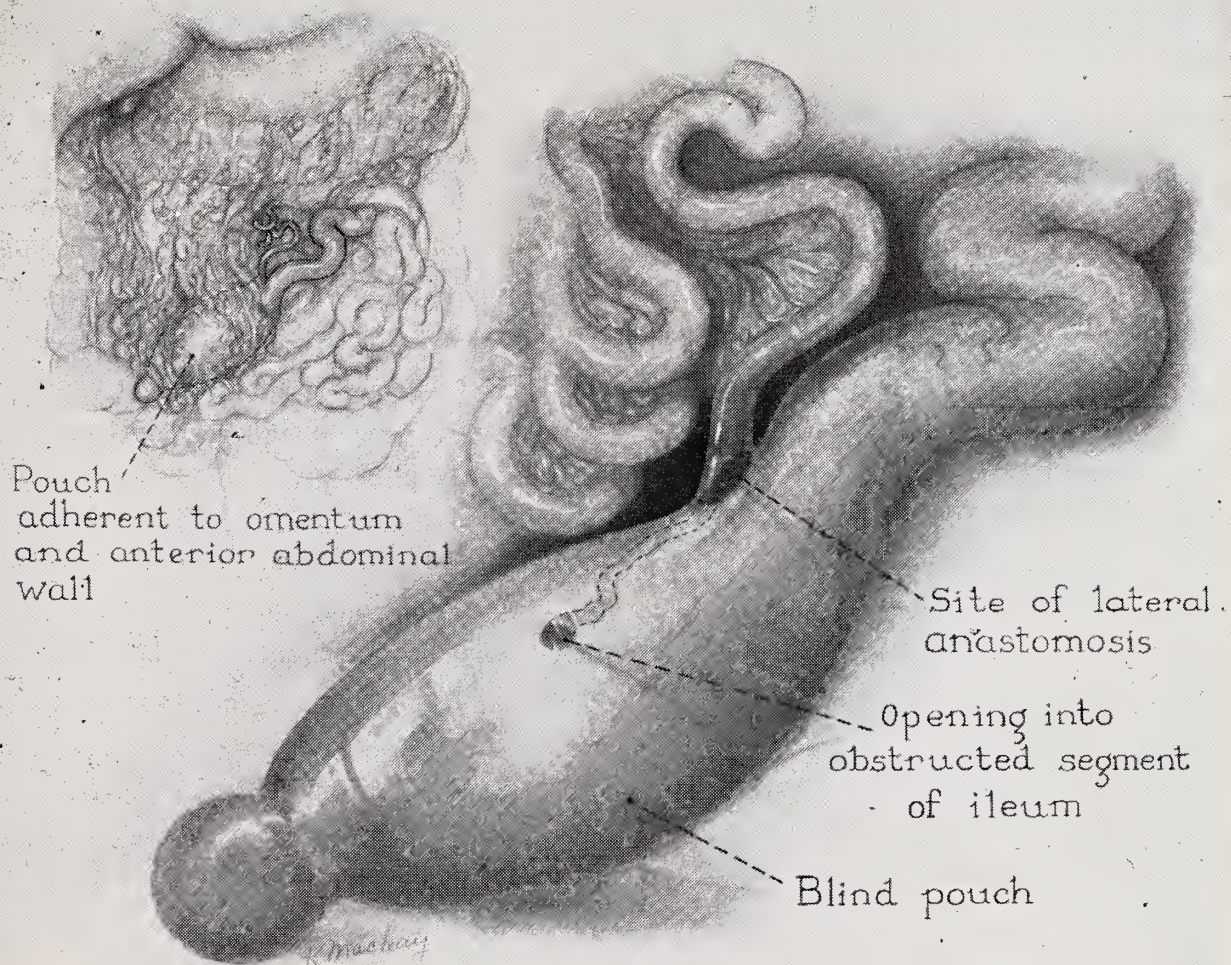


Figure 5

now been approximately five months since the operation. She has gained 33 pounds in weight and has had no further episodes of abdominal cramps. She is having from one to two normal bowel movements daily. She has had no further bouts of nausea and vomiting.

Previous case reports, as well as animal experiments, have indicated that when an operative procedure leaves behind a blind intestinal loop, the foundation is laid for the development of a symptom producing pouch.¹ Two situations can give rise to such a blind loop. One, as in the case presented, occurs when an obstructed loop is simply by-passed and left in place. The other occurs following resection and side-to-side anastomosis when the proximal closed stump is left unduly long.² Admittedly, these situations are now rare, since modern surgical technique precludes the leaving of a long proximal stump, and obstructed loops are no longer by-passed. Should such a blind loop exist, however, the intestinal contents may stagnate and balloon the segment into a

wide pouch. Infection and ulceration and occasionally perforation may develop.

A variety of symptoms including nausea, vomiting, constipation, distention, anemia, diarrhea, fever, and malnutrition may occur. Macrocytic anemia similar to that seen in lesions of the right colon has been reported. Its pathogenesis is not clear. The case presented had a normocytic anemia. Episodes suggesting intestinal obstruction have been a prominent feature in reported cases. These symptoms were certainly paramount in the case presented. The exact mechanism of the obstruction is difficult to explain since mouth to anus continuity was maintained through the widely patent lateral anastomosis. Roentgen studies showing air containing, distended bowel proximal to the pouch plus the hypertrophy of the jejunum noted at operation are conclusive evidence that obstruction did exist. The only mechanical obstruction, however, was in the by-passed loop. It can be postulated that when the pouch was mildly distended, a reflex hyperperistalsis occurred

with the resulting diarrhea. As more marked distention of the pouch developed, a reflex ileus resulted. It has been shown in experimental animals that balloon distention of a surgically isolated loop of bowel will produce a picture which is indistinguishable from that of obstruction, even though bowel continuity is maintained.

Similar symptoms are encountered much more commonly in a large variety of clinical conditions. Adhesions and retained surgical sponges are usually considered first in a post-operative patient with recurrent intestinal obstruction. Aside from post-operative states, abdominal malignancy, diverticulitis, renal infection, volvulus, internal hernia, recurrent intussusception, sprue, regional enteritis, tuberculosis, actinomycosis, and collagen disease enter into the differential diagnosis.

The roentgen findings³ are of positive value in differentiating this condition from the numerous clinical entities listed above. The diagnosis is not difficult if one bears in mind the possibility of its presence. The films demonstrate a collection of barium mixed with the intestinal contents which tend to remain in one location while the bulk of the barium stream continues on into the colon. The

overall boundaries of the barium collection are usually rather smooth and rounded, suggesting a discrete structure rather than an abscess cavity. A fistulous tract is ruled out by the fact that the collection of barium is not in the colon and remains in one place. In our case, the barium remained in place for 24 hours after the remainder of the small bowel had emptied.

By tying together the clinical symptoms, roentgen findings, and history of previous surgery, an accurate evaluation prior to surgery is possible.

Summary

A case report of a patient with recurrent obstruction over a 15 year period as the result of a bypassed blind intestinal pouch is presented. Its pathogenesis, symptomatology, and diagnostic clinical and x-ray features are discussed.

724 Hemlock Street

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Pertinent Facts

A STRIKING TWO-COLOR offset reproduction of the revered Hippocratic Oath is now available from the American Medical Association's Order Department, \$1 each, postpaid. Printed on quality Crane parchment stock, the reproduction measuring 11 3/4 by 15 1/4 inches is suitable for framing. Many physicians are placing copies of the oath in their offices and waiting rooms.

A supplement to the booklet *Immunization Information for International Travel* has just been released by the Public Health Service of the Department of Health, Education, and Welfare. It carries changes made in immunization requirements from June 1954 to June 1955. Persons having a 1954 edition of the booklet may obtain copies of the supplement, free of charge, from the U. S. Public Health Service, Division of Foreign Quarantine, Washington 25, D. C.

The booklet, including the new supplement, may be purchased for 20 cents from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. A 25 per cent discount is allowed on orders of 100 copies or more delivered to the same address.

An attractive new leaflet earmarked "for patients only" was distributed in September to members of the AMA. Entitled "To All My Patients," this

12-page pamphlet (for physicians to distribute to patients) explains the roles of various persons on the medical team in providing good medical care. In addition, the booklet briefly discusses medical and hospital fees and health insurance. Designed primarily to promote better doctor-patient relationships, the booklet also provides space for the doctor's name, address and office hours to be inserted at the end. Quantities will be available on request from the AMA Public Relations Department.

"It is unlawful for any person or persons to practice professional nursing as a graduate nurse or registered nurse without a certificate from the Board of Examiners of Nurses for Georgia; and any person violating any of the provisions of Chapter 84-10 shall be guilty of a misdemeanor . . ." (Law Governing the Practice of Nursing in Georgia, Section 84-9915)

To work in the state of Georgia as a graduate or registered nurse it is necessary to obtain a certificate of registration or a temporary permit. This certificate of registration must be renewed annually. Applications for interstate licensure can be obtained from the Board of Examiners of Nurses for Georgia, 116 Mitchell St., S.W. Annual renewal fees are payable at this address on or before February 28th of each year.

The Choice of Drugs in the Prophylaxis of Rheumatic Fever

J. GORDON BARROW, M.D., Atlanta, Ga.

THE WELL AUTHENTICATED relationship between infections with Group A streptococci and clinical flare-ups of acute rheumatic fever,¹⁻⁵ has made the prophylaxis and treatment of these infections of great practical importance. The Cardiac Clinic at Grady Memorial Hospital in Atlanta has afforded an excellent chance to study the use of various methods of treatment and prophylaxis where good follow-up is available. The study group consists of around 350 cases of rheumatic fever or rheumatic heart disease. Since this is a charity service, the incidence of streptococcal exposure is high.

Since 1949, adequate personnel have been available consisting of a half-time medical director, a full time fellow in cardiology, a public health nurse as clinic nurse, a medical social worker, a clerk and two secretaries, and four public health "specialized" cardiac field nurses for home follow-up. With this highly trained group it has been possible to follow the cases closely.

The prevention of rheumatic fever is naturally divided into two phases: (1) the long term prophylaxis of streptococcal infections in known susceptible individuals by the use of continuous small doses of medication and (2) the treatment of any acute respiratory infection which may be streptococcal which occurs in spite of prophylaxis or in non-protected susceptible individuals.

In the first phase, our largest experience has been with sulfadiazine. At the time our study was organized, sulfa prophylaxis had already received wide attention.⁶⁻⁸ Our practice is to place every patient who has had acute rheumatic fever within the preceding five years on prophylactic sulfadiazine. The dose is estimated according to age and weight. Under five years of age, 0.5 Gm. daily is given. Over five years of age, but under 100 pounds in weight, 1.0 Gm. daily is given, and all over 100 pounds in weight received 1.5 Gm. daily. This dose is continued all year without interruption until the patient is 17 years of age or in older patients until a total of five years has elapsed without a recurrence.

We have now had experience with over 850 patient-years of sulfa prophylaxis, and this experience can be summarized as follows:

(1) This method of prophylaxis is cheap and effective. In 850 patient-years only 12 clinical recurrences of rheumatic fever have been noted. This is an incidence of only 1.4 per cent compared with an average recurrence rate in numerous control groups of from 15 per cent to 20 per cent each year.⁹⁻¹⁰

(2) Good cooperation of the patients is noted. Among other reasons, the ease of administration and pleasantness of the drug and the very close home follow-up of our visiting nurses deserve mention.

(3) Toxicity of the sulfadiazine has not been a problem in this dosage range. Agranulocytosis has not been noted in any patient. We no longer consider routine white blood counts necessary after the first two months on the drug. As a precaution, however, if a patient is uncooperative and will not take his drug regularly, it is discontinued since we feel that intermittent therapy greatly increases the risk of serious toxic reactions. The only toxicity we have seen has been skin rash in three patients, and this disappeared uneventfully on discontinuing the drug.

This is probably still the best prophylactic drug for large groups of patients in charity services where cost of drugs is a problem.

In recent years, however, penicillin has been studied widely as a prophylactic agent against streptococcal infections and has proven very effective.¹¹⁻¹² The least effective dose has not been settled, but 200,000 U. of oral penicillin twice daily is probably a safe dose until further work is completed. Intermittent therapy has been used successfully,¹³ but most authorities recommend continuous therapy. This is doubtless the most effective prophylaxis available if cost is no object. The incidence of penicillin reaction has been small (around 0.5 per cent) with oral penicillin.

A recent innovation has been the use of the long acting benzathine penicillin* as prophylaxis. One injection of 1.2 million units is sufficient to give adequate blood levels for 30 days,¹⁴ and thus a single

*All-Purpose Penicillin® (Wyeth).

Dr. Barrow is director of Cardiac Clinic, Grady Memorial Hospital, and Associate in Medicine, Emory University School of Medicine.

monthly injection suffices. We gave this method a brief trial but had to abandon it because of the painfulness of the injection. It was so painful that many patients refused to come for their injections, and we believe for this reason that this method of prophylaxis is not ideal. It is probable that fewer patients on a charity service would continue prophylaxis for the optimum number of years with this monthly injection than with oral sulfa or penicillin, and for this reason we have abandoned the use of this type prophylaxis except in selected patients for the present.

The wide spectrum antibiotics are not only expensive, but are not as effective as penicillin and should be reserved for those patients who are sensitive to both sulfa and penicillin.

Prophylaxis alone is insufficient for the prevention of rheumatic fever. In susceptible individuals (those who have had a previous bout of rheumatic fever) any infection which may be streptococcal must be treated vigorously. Sulfa has proven to be inadequate in that it is only suppressive and will not eradicate the infection completely,¹⁵ and thus will not prevent rheumatic fever. Penicillin has been found effective in this regard,¹⁶ and the necessary blood levels and duration of treatment have been well worked out by the Streptococcus Disease Laboratory at the Warren Air Force Base.⁶⁷ In general a blood level of greater than .04 units per cc. for a total of at least 10 days is necessary to completely eradicate the streptococci, and the sooner treatment is begun after clinical symptoms have begun, the fewer rheumatic fever flare-ups will follow. There is recent evidence, however, that treatment instituted as late as nine days after the onset of symptoms will be of definite value.¹⁵ Since it is very difficult to differentiate without culture which respiratory infection is streptococcal and which is not, we have set out certain rules by which our nurses can judge which patients should receive prophylaxis, since it is impossible for a doctor to see them all and since throat culture reports are not available for three days, patients are instructed to report any sore throat or respiratory infection with fever. They are examined by the nurse, and, if the throat is obviously red or infected or if the temperature is over 100° F. orally, they are considered to be potential streptococcal infections. A throat culture is made, and without waiting for a report those fitting the above criteria are treated.

The first routine to be tried was 600,000 U. of aqueous procaine penicillin every other day for three doses. In over 700 courses of treatment over a three year period in susceptible individuals, we experienced only one flare-up of rheumatic fever during the three week follow-up period. Of the throat cultures made at the onset of the disease only one out of 10 was

actually positive for Group A beta hemolytic streptococci. This low incidence was probably due to three factors: (1) many of the patients were receiving sulfa prophylaxis which suppressed any streptococcal infection present and made it more difficult to culture, (2) the culture techniques were only the routine ones used in a general hospital and were not especially designed for this purpose, and (3) since a nurse usually had the responsibility of deciding if the patient met the criteria outlined, there was a tendency to bend over backward to treat any streptococcal throat, and I am sure that many other types of respiratory infection were treated.

However, it is important to note that follow-up cultures in the 64 patients in whom streptococcus could be isolated were all negative three weeks after this series of treatments, and the record of only one rheumatic flare-up was in an individual who had a negative initial culture.

Because of the necessity for three injections of procaine penicillin, when Benzathine Penicillin became available it was immediately given a trial as treatment for the streptococcal infections. The same methods of selection, culture, and follow-up were used. Slightly more than 400 courses of treatment were given consisting of a single 600,000 U. dose of Bicillin I.M. Of this group in whom initial positive cultures were obtained, there were three cases in whom streptococci could still be cultured from the throat three weeks later, and even more important two of these three had a definite flare-up of rheumatic fever with carditis.

Because of this unfortunate experience, it was decided that this treatment was unsatisfactory, and a better method was sought. It was noted that clinically the patients did not respond as rapidly to the Bicillin as they did to aqueous procaine penicillin, and it was postulated that high initial blood levels might be important. With this in mind we began to use one injection of a mixture which consists of 300,000 U. crystalline penicillin, 600,000 U. aqueous procaine penicillin and 600,000 U. Bicillin in a 2 cc. dose.* To date, our results with this have been most satisfactory. We have only given 220 courses of treatment, but there has been no follow-up culture positive and no flare-up of rheumatic fever. This is, of course, too small a group on which to base a decision, but it seems to us that this type preparation, which offers the advantage of initial high blood level plus long continued blood levels (15 days) and the additional advantage of only one injection, is the preparation which may be the answer to the treatment of streptococcal infections in potential rheumatic patients.

*Bicillin,® Wyeth & Co.

Summary

Our present method of prophylaxis of rheumatic fever in known susceptible individuals consists of sulfadiazine orally in doses depending on the age and weight of the individual for at least five years after the latest recurrence or until the patient is 17 years of age. In addition, the patient receives immediate treatment for any respiratory infection which may be streptococcal. This treatment at present consists of a mixture of crystalline, aqueous procaine and benzathine penicillin given as a single injection. These two methods used together should reduce the recurrence rate of rheumatic fever by over 98 per cent.

36 Butler Street, S.E.

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Veneral Disease Rate Rises

THE DECLINING VENEREAL DISEASE rates of past years prompted an optimistic demobilization of venereal disease control forces including a reduction in case-finding, diagnostic and treatment facilities.

The venereal diseases are on the rise again. In the last six months of 1954, 43 states, Georgia included, reported a rise in cases of early syphilis or gonorrhea or both.

The highest rates for early stages of syphilis and gonorrhea are in the age group 20-24, many of whom acquired their infection during the teen years. It is estimated that one out of every 200 teen-agers in the United States contracted gonorrhea in 1953. Venereal diseases continue to be a health problem primarily of young people. Areas near military establishments or defense plants usually have particularly high VD rates.

The gravity of the venereal disease problem can be judged from the U. S. Public Health Service estimates that 1,921,000 people in this country have syphilis requiring treatment, and that last year 87,000 persons acquired syphilis and 1,000,000 contracted gonorrhea.

A review of more than 250 publications on the

diseases last year indicates that although great strides have been made in venereal disease control, complete eradication is far from being accomplished. The review appeared in the *Archives of Internal Medicine*, published by the American Medical Association in February of this year.

Although for the country as a whole, the venereal disease rates are not as high as they were ten years ago, they still represent one of the nation's foremost health hazards, and VD still disables, disfigures, and kills.

A frightening aspect of syphilis is the swift progress of an untreated infection in a population. A single infection in a middle Georgia city spread to 211 young people within six weeks. Seventy of them contracted syphilis.

Many cases of venereal disease are not now being found until after the first symptoms have disappeared. In this way carriers of infection are active, usually within the group of young people for which there is greatest concern. These young people whose infections go undiscovered and untreated are candidates for disability and premature death from one of the few easily preventable chronic diseases.

The Milk-Alkali Syndrome

ARTHUR M. KNIGHT, JR., M.D., Waycross, Ga.

A 42-YEAR-OLD WHITE, male laborer was admitted to the hospital on March 25, 1955, complaining of nausea, vomiting, epigastric pain, and headache. He gave a history of having had a duodenal ulcer for many years, and the hospital records of G. I. series done on several previous admissions confirmed this fact. For the past 10 years he had been drinking at least one quart of milk daily. Before July 1954 he took only occasional doses of sodium bicarbonate, and his ulcer was treated with aluminum hydroxide, magnesium trisilicate, banthine, and bland diet. In July 1954 he started taking calcium carbonate powder gr. v every four hours. Because this proved to be constipating, he added sodium bicarbonate gr. v every four hours to the regimen. The milk was continued. The dosage of soda was soon reduced somewhat because it caused loose stools. In December 1954 his epigastric pain became so severe that he started taking the calcium carbonate every hour. Milk was continued but magnesium oxide was substituted for the sodium bicarbonate and taken as often as needed to control constipation. At this time his physician recommended a gastric resection, but the patient refused it. Therefore, he was hospitalized for intensive treatment and given milk and calcium carbonate every hour for 10 days. This helped his epigastric pain so much that he continued to take both milk and calcium powder frequently until the time of his present admission.

His past history was negative for renal disease, and urinalyses on his previous hospital charts were all negative with urine specific gravities ranging from 1.010 to 1.020. There was no history of vitamin D ingestion.

Complete physical examination revealed nothing remarkable. The patient was tall and thin. Temperature, pulse rate, and respiratory rate were normal. B. P. was 110/70. There was slight tenderness in the mid-epigastrium.

The patient's urine was persistently alkaline with a specific gravity of 1.010 to 1.012. It contained a trace to 1+ albumin and 3 to 4 W.B.C. per high power field. N.P.N. was 72 mg. %. CO₂ combining power, sodium, potassium, and chlorides were normal. Serum calcium was 15 mg. % (control 10) and phosphorus 3.2 mg. % (control 3.4). G. I.

series revealed a deformed duodenal bulb. K.U.B. was negative. A urologist cystoscoped him and reported no obstruction in either ureter. Chest x-ray and complete bone survey were negative. The E.C.G. was normal.

Treatment consisted of prantal, gelusil, and a diet low in protein (40 Gm.) and calcium (100-150 mg./day). By the fourth day his NPN had fallen to 54 mg. %, and he felt much better. By the 16th day his NPN was 48 mg. %, and serum calcium and phosphorus levels were reported to be normal. PSP excretion (I.V.) was 15% in 30 minutes and 7% in one hour (total 22%). The patient was placed on a low calcium diet, prantal, and non-absorbable alkali. He has continued to improve.

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Comment

THIS IS ALMOST CERTAINLY an example of the interesting "milk-alkali syndrome" first fully described as an entity by the Albright group at the Massachusetts General Hospital in 1941.¹ The peptic ulcer, the excessive consumption of soluble alkali and of milk with its high content of calcium and phosphorus, the hypercalcemia, and the reversible uremia are all here. The only additional features one might wish to see are a metabolic alkalosis, a normal rate of urinary calcium excretion, and areas of ectopic calcification, especially in the cornea and subconjunctival area. Recently Kessler² collected a series of 21 such cases so they are not rare.

Because improvement occurs when the intake of milk and alkali is reduced it is tempting to think that this sickness is simply a matter of surfeit. In point of fact, however, almost none of the chemical deviations can be explained. The only certainty seems to be that this type of uremia is different from the usual variety which is conventionally marked by hyperphosphatemia, hypocalcemia, acidosis, aciduria, a negative calcium balance, and anemia.

The difficulty cannot be due in every instance to alkalosis because this patient's plasma CO₂-combining power was normal. This is a bit surprising as

most of the recorded cases had a mild metabolic alkalosis but it is not an essential finding. Although it is commonly thought that alkalosis depresses kidney function there is no convincing evidence that this is so. It is true that acute alkalosis is often accompanied by azotemia and even by degenerative lesions in the renal tubules, but these are more likely to be due to dehydration, shock, or to potassium deficiency. Sanderson³ gave as much as 140 gm. of NaHCO_3 in 31. of milk daily for three weeks to ulcer patients; the plasma concentrations of CO_2 and sodium each rose by about 7 mEq./l. but neither proteinuria nor azotemia occurred, and the patients had no symptoms except edema. During therapy the renal clearances of inulin and creatinine actually increased and fell rather abruptly when alkali was withdrawn. Evidently the average human can tolerate large doses of alkali with impunity. There must be some other explanation for the uremia.

The renal lesion could be related in some way to the hypercalcemia, but that in itself requires explanation on two accounts. In the first place, it is extremely difficult to raise the serum calcium concentration at all by drinking any reasonable quantity of milk, and, secondly, this hypercalcemia is the only one (others are due to hyperparathyroidism, vitamin D intoxication, sarcoidosis, carcinomatous involvement of the bone marrow, myeloma, acute osteoporosis, etc.) which does not also induce hypercalcuria. To be sure, this item is not recorded in the protocol, but the literature on the subject repeatedly points out that the Sulkowitch test is negative in the milk-alkali syndrome. Since almost nothing is known about the manner which the normal kidney excretes calcium, it is idle to speculate about the abnormal. Conceivably, however, this retention of calcium could be due to the fact that the excess calcium in the blood is in a colloidal and therefore non-filtrable state. More probably, however, an abnormally heavy load of ionized calcium is filtered through the glomeruli to be resorbed by the tubules with unusual efficiency. Nothing is really known about the mechanism required for transporting this ion—or any other ion for that matter—from tubule lumen to peri-tubular capillary. It may be supposed, however, that somehow renal epithelial cells too full of calcium cannot perform their other duties with satisfaction. The renal lesion is probably due therefore to the hypercalcemia; while alkalosis favors calcium precipitation it is not a requirement. Excessive milk-drinking without additional alkali has caused this syndrome. It is important to know that mild early nephrocalcinosis may be demonstrable only by the micro-incineration technic, and not by the usual histological methods.

If it is permissible to substitute more speculation

for fact, the ulcer patient who cannot tolerate milk and alkali may be thought of as one who also has a metabolic abnormality of the renal tubule which gives priority to the transport of calcium at the expense of other substances. Isolated enzymatic defects in renal function, often on a genetic basis, are being recognized with increasing frequency. For example, an inherited inability to resorb phosphorus properly produces the picture of rickets relatively resistant to vitamin D therapy, while a tendency to resorb phosphorus in excess causes pseudo-hypoparathyroidism. The commonest cause of recurrent kidney stones is idiopathic hypercalcuria, an inherited inability of the kidney cells to resorb calcium properly; it is possible that the subject of this protocol was born with the opposite condition, a tendency to resorb calcium too readily. Renal physiology is now in the hands of the enzyme chemist and the geneticist. In the meantime, it is fortunate that the lesion under discussion is reversible if the calcium load is diminished in time:

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TREATMENT IN THIS CASE promptly corrected some of the abnormal chemical values. Whether or not renal function will continue to improve cannot be predicted. In some cases of the ulcer-milk-alkali syndrome, initial improvement following dietary correction has been followed by deterioration of renal function. Nephrocalcinosis and renal failure are the dangerous sequelae. In cases of this kind that reach a stage of nonreversible renal failure, the diagnostic chemical changes are altered by phosphorus retention, declining serum calcium values, and acidosis. Since anatomical studies of these cases are scarce, it would be premature to offer any opinion about what such studies might or might not contribute to an understanding of pathogenesis. The development of a technique for needle biopsy of the kidney and the expanding field of enzyme histochemistry offer considerable opportunity for profitable investigation of renal diseases. That might be true in this interesting disease.

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AC

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Psychotherapy for the General Practitioner

WINSTON E. BURDINE, M.D., and MYRON T. WEINER, M.A., Atlanta, Ga.

PSYCHOTHERAPY IS A LEARNING process in which the patient is intrinsically motivated by unhappiness to seek help in finding satisfaction for his needs.

The patient is aware of this unhappiness. He is also aware, in varying degrees, of his problems and their causes. He assumes that he knows the problems and that the doctor will solve them for him. A very superficial type of psychotherapy would do just that. However, as new problems arise for the patient he would have to again visit the doctor. On the other hand, if the physician saw his task as one of teaching the patient to solve problems, more time would initially be necessary, yet it would be economically spent if the patient did not have to return after having once learned to solve problems.

With the above philosophy we can see that the patient's problems are only examples to be used as material for the basic learning task—learning how to solve problems. In this light we can logically analyze psychotherapy into various phases. First, it is necessary to clearly define the example problems; second, the origin of the problems must be specified; third, consideration of possible solutions in the light of anticipated results; fourth, carrying out the solution, evaluation, and repetition of the above until an adequate solution is reached; fifth, examination of the process.

The difference in background of patients and therapists negates the possibility of the patient's learning the process if the therapist carries it out. The patient must learn to use his own resources in carrying out the process, therefore he must be the one to solve the example problem.

What then is the therapist's role? It is to teach the patient to use methods and evaluate his use of them so as to increase his proficiency. If we be teachers then our interest is focused on the patient's ability to solve problems and not on the solutions he reaches. We assume that as his proficiency in problem solving increases, the patient's solutions will be more adequate. We do not direct his goals or plan his direction. If the patient can solve problems, he can soon learn direction and goals which satisfy his

needs. For example, a patient who is disturbed by his homosexuality may direct his attention toward becoming either adjusted to homosexuality or to a more socially acceptable way of life. We do not evaluate his goal but only the adequacy of his adjustment in relation to his goal. Our philosophy assumes that its first principle is that every individual has a drive to reach homostasis in reference to his needs. Logical analysis gives us our next principle: that satisfying a need is reaching homostasis, while a neurotic defense yields protection but not satisfaction. If this be true, everyone should be normal or approaching normality. However, the significant point has been omitted. Although we may assume that every individual has a drive toward normality, we cannot also assume that this drive can motivate problem solving behavior unless: (1) the individual has learned to solve problems and (2) the individual feels free to use his knowledge. Should not a third condition state goals so that the individual will have direction for his problem solving behavior? No, the goals are inherent in the basic personality structure. Only deep therapy, such as psychoanalysis, even attempts such change in basic structure. The psychotherapist's aim is to help the patient adjust to himself.

How can we help the individual feel free to use his knowledge? This is a stumbling block that either makes or breaks a therapist. It is also an ideal toward which therapists must strive. We believe two separate and distinct factors are involved. The first is understanding of an intellectual nature; the second is understanding of an emotional nature. We learn intellectual understanding through reading on personality theory and its practical application. We also learn this through experience. Basic to emotional understanding is normality in the therapist. He must be objective in his understanding of the patient. Emotional understanding also assumes that the therapist's own personality is such that he is interested in helping others—in other words, derives satisfaction of needs in this type of work.

Techniques of using these basic principles differ, probably due to differences in personalities. However, the therapist must begin with a technique before he can modify it to suit his own personality. We

have found the following outline quite suitable for the beginning therapist: first, a theoretical personality framework is essential for intellectual understanding. English and Pearson in their book "Problems of Everyday Living" set forth a very satisfactory outline of analytic theory which is quite practical for the novice. With this basic intellectual understanding and emotional understanding, either natural or counseled, the therapist may meet his patient on

equal terms, friend to friend, and together travel a path never to be forgotten. Not only does the patient grow in self-understanding, means of satisfying personal needs, and therefore happiness, but the therapist also grows in knowledge, understanding, and personal insight. If the therapist has not changed, neither has the patient.

384 Peachtree Street, N.E.

Guard Against Accidents

ACCIDENTS CLAIM THE LIVES of about 2,000 Georgians yearly. Nearly 130,000 major home injuries occur in Georgia each year, according to studies conducted by the Home Safety Unit of the Georgia Department of Public Health.

Accidents of all types, by far the leading cause of death of children, account for over 30 per cent of all deaths between the ages of one and 15. Past progress in the conquest of childhood diseases has been remarkable. As a consequence, more time and attention can now be given to the growing threat of accidental injuries and deaths.

In the group one through 14 years of age, accidents took a substantial lead in the first five causes of death in Georgia in 1954, the last year for which complete records are available by age groups. The first five causes were: 1. Accidents, exclusive of motor vehicle—200 deaths, 2. Motor vehicle accidents—127 deaths, 3. Pneumonia and influenza—123 deaths, 4. Congenital malformations—92 deaths, 5. Cancer—82 deaths.

Mechanical suffocation leads the list of fatal home accidents of infants. Despite evidence indicating that many of the deaths attributed to this cause are actually overwhelming respiratory infections, the safety precautions associated with this type of accident are still of primary importance.

Give the baby his own little bed, even if it is merely a basket, box, or bureau drawer. Keep the bed bare of pillows and other bed linens that might cause suffocation.

Hazards anywhere in the house or on the premises are a threat to the child in the second half of his first year. Care should be taken to keep poisons and other dangerous objects out of his reach.

The age group from one to five has a fatal home

accident rate second only to the extreme age groups—under one and over 65. Education of the child in the prevention of accidents should begin as the busy youngster exercises his normal impulse to learn and do for himself.

Two single causes of accidental deaths stand out in the age group one through four. They are *burns and poisoning*. There were more deaths caused by fire and poisoning in this age group than in the combined ages five through 24.

Children in the five to 14 age group are exposed to more risks than are encountered in earlier years. Supervision, while still important, needs to be augmented by education in accident prevention.

While fire continues to be the leading cause of fatal home accidents for the five to 14 age group, *firearms* enter as a major problem accounting for more than twice the number of fatalities attributed to the next three leading causes. Burns, though, were responsible for more than half the home accident deaths reported for this age group in 1953. A study of 394 fatal home accidents in Georgia resulting from fire showed that in more than one-fourth of these deaths, the fatality was caused by clothing igniting.

The home accident rate is at its lowest point in the age group 15 to 24, with a death rate per 100,000 population of only 4.9. The rate increases after this until it reaches a peak of 222.9 per 100,000 for the population over 75.

With an ever increasing percentage of Georgia's population over 65 years of age, the need for accident prevention assumes greater proportion. Over 30 per cent of the total fatal home accidents in Georgia involve persons in this age group.

Falls and burns account for practically all the fatal home accidents involving the over 65 age group.

Two Stage Repair of Congenital Chordee and Hypospadias

SAMUEL S. AMBROSE, M.D., Atlanta, Ga.

APPROXIMATELY 150 DIFFERENT surgical procedures for correction of male hypospadias have been described during the past half century. This is not an attempt to further confuse the scene, on the contrary it is a plea for wider use of a surgical principle which admirably fits the requirements for a simple, satisfactory urethroplasty. The technique which will be described is fundamentally that of Denis Browne^{3 4 5} who developed it from the basic principle that a strip of epithelium if buried in the subcutaneous tissues will autonomously curl and form an epithelialized tube. Hamilton Russell⁶ was the first to recognize this inherent ability of epithelial tissue.

Fortunately, in the majority of cases, the degree of hypospadias is glandular, and any attempt at correction beyond dorsal meatotomy if the orifice is small belongs in the realm of meddlesome, unnecessary surgery which is likely to result in a stricture or a greater degree of hypospadias. If, however, hypospadias of penile, penoscrotal, perineal, or pseudo-vaginal degree exists, construction of a channel to the glans is warranted. These individuals will have improved placement of ejaculate, improved management of their urinary stream, and the psychological outlook for both child and parents will brighten.

Hypospadias in the male is considered by many to be a degree of pseudo-hermaphroditism, or intersex, which possibly resulted from over feminization of the male fetus during the early development of the genital organs. The greater degrees of urethral defect are frequently associated with Mullerian remnants varying from a simple cyst of the utricle to complete vagina, cervix, uterus, and Fallopian tubes which open into the urethra at the verumontanum. Chordee may represent changes associated with the development of a clitoris.

Congenital chordee must be completely eliminated before a satisfactory end result can be obtained. Straightening of the penile shaft should be accomplished by the end of the second year of life so that normal development of the penis can proceed.

In our hands, simple transverse incision of the ventral surface of the penis with section of restricting fibers followed by longitudinal closure has produced unsatisfactory results. Optimum straightening and lengthening have only been accomplished when all fibrous subcutaneous tissue on the ventral surface of the penis from the urethral orifice to the glans has been resected. This includes all fibrous tissue superficial to the tunica albuginea of the corpora cavernosa in this area, and resection usually extends into the septum between the corpora. If adequate penile lengthening has resulted, skin from the prepuce is usually necessary for closure and is actually desirable for subsequent use in urethral construction. The method for shifting the prepuce described by Blair² has been quite satisfactory and does not require the two stages used by Edmunds.⁷

An incision circumscribing the penile shaft at the coronal sulcus frees the prepuce. The adjacent layers of the prepuce are bluntly separated producing a large, full thickness flap. This flap is split by a longitudinal dorsal incision producing two single pedicle flaps which are swung on either side of the penis and approximated with 00000 chromic catgut in the midline on the ventral surface and to the mucosal cuff distally. Adequate covering of the penile shaft results, and the excess skin in the prepuce is shifted to the site of urethral construction. A tension suture through the glans is used to maintain erect penile position during healing, and a large pressure dressing of cotton waste and tensor bandage prevents excessive edema. Within four to six months, healing has progressed sufficiently so that one may proceed if it is desired to the second stage or urethroplasty.

Denis Browne³ has clearly pointed out the requirements for a satisfactory urethroplasty. “. . . It must be (1) applicable to all degrees of the deformity . . . , (2) . . . construct a urethra free from hair on the inside . . . , (3) . . . must be of a size and elasticity approximately normal . . . , (4) . . . be capable of completion by the time the child first goes to school . . . , and (5) . . . be capable of consistent performance by any reasonably skillful surgeon . . .”

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, May 1-4, 1955.

In 1949 when we first learned of Browne's work, Dr. E. P. Alyea and I investigated the behavior of strips of epithelium buried in the subcutaneous tissues of the abdomen of dogs. These studies¹ indicated that (1) a strip of epithelium four to 15 mm. in width would curl and form a completely epithelialized channel in 11 to 14 days, (2) a strip 10 to 15 mm. in width would form a tube 18 to 20 French in diameter and that approximately one-fifth of the circumference would represent new growth of epithelium, (3) a splint of polyethylene caused either breakdown of the tube or marked delay in closure, (4) catgut or silk closure with one layer buried in the subcutaneous tissue and one layer approximating the skin were equally satisfactory, and that (5) observation for five and one-half months revealed no tendency toward stricture formation. These results correspond quite closely to those of Nesbit⁸ who did a similar study in rats.

We were encouraged to apply the Browne technique to clinical material. Although we adhered to his published procedure, our initial results were disappointing due to fistulae which occurred at pressure points beneath stay sutures used as the first layer of closure. Subsequently, we learned that our stay sutures were too snug, and compounding this fault was an inadequate dorsal slit. These two points cannot be overemphasized as they are the usual source of poor results with the Browne urethroplasty. Our inability to use the rather elaborate stay sutures described by Browne prompted the use of buried subcutaneous sutures which combined with an adequate dorsal relaxing slit has resulted in primary closure of our subsequent urethroplasties with a minimum of complications.

The urinary stream must be diverted from the operative field by either perineal urethrostomy or suprapubic cystostomy. We prefer a perineal urethrostomy using a No. 12 or No. 14 French Foley catheter, although Browne uses a mushroom catheter. Suprapubic cystostomy is more laborious to perform and does not always keep the operative site free of urine. The urinary stream remains diverted for 14 days, after which time the catheter is removed and the patient allowed to void. The urethrostomy wound closes rapidly, and no strictures or fistulae have been encountered at this point.

When the urethrostomy is completed, attention is directed to the penis, and a small silk suture is passed through the glans for traction during the operation and subsequently during healing. This is removed on the fifth day, and no disfiguring scar has occurred. If the degree of hypospadias is penile or peno-scrotal, a tourniquet about the base of the penis facilitates the dissection. Two parallel longitudinal

incisions are outlined on the ventral surface of the penis outlining a midline strip of epithelium from 7.5 to 10 mm. in width or wider depending upon the size of the organ. These incisions are carried around the proximal edge of the hypospadiac urethral orifice and joined, leaving a one to two mm. cuff of epithelium about the orifice on the lateral and proximal edges. If the orifice is small, a ventral meatotomy is performed; but Browne suggests this be done in all cases. Distally, the two longitudinal incisions are carried onto the glans; and lateral to this point, a small triangle of glandular epithelium is removed so that healing of the lateral flaps will advance the meatus to the ventral surface of the glans. The longitudinal incisions are carried down to the tunica albuginea of the corpora, and the lateral skin flaps including Buck's fascia are then widely mobilized. This insures thick flaps which will produce when approximated a thick ventral covering for the urethra. (Figure 1) Bleeding can usually be controlled by pressure; but if necessary, ligatures of 000 plain catgut or coagulation are used. Following the technique of Browne, two small stab wounds are made in the scrotum and small rubber drains are drawn into the lateral crevices of the flaps. This reduces swelling, and they are removed in 48 hours. Closure of the lateral flaps over the epithelial strip

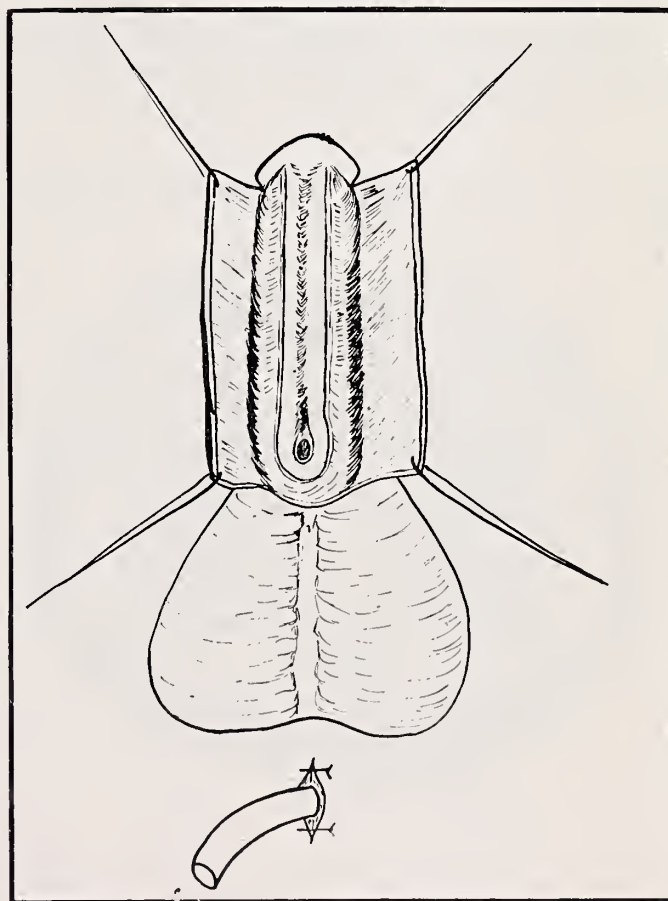


Figure 1
The ventral epithelial strip has been outlined and the lateral flaps developed adequately. A perineal urethrostomy catheter is in place.

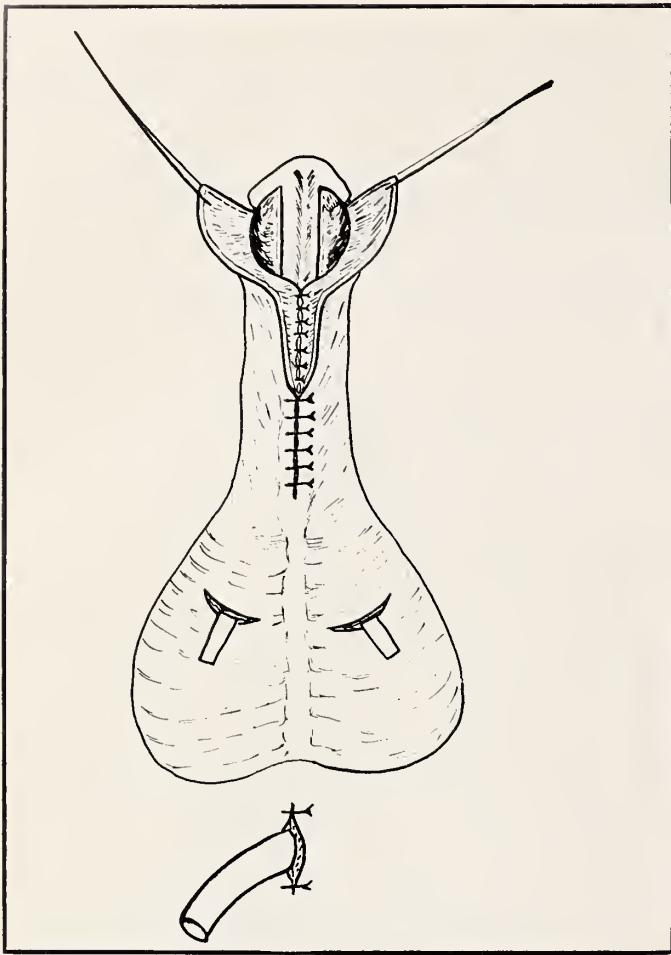


Figure 2

The lateral flaps are partially approximated illustrating the position of the first layer of subcutaneous interrupted sutures and the approximation of the skin edges. Rubber drains are brought out through stab wounds in the scrotum.

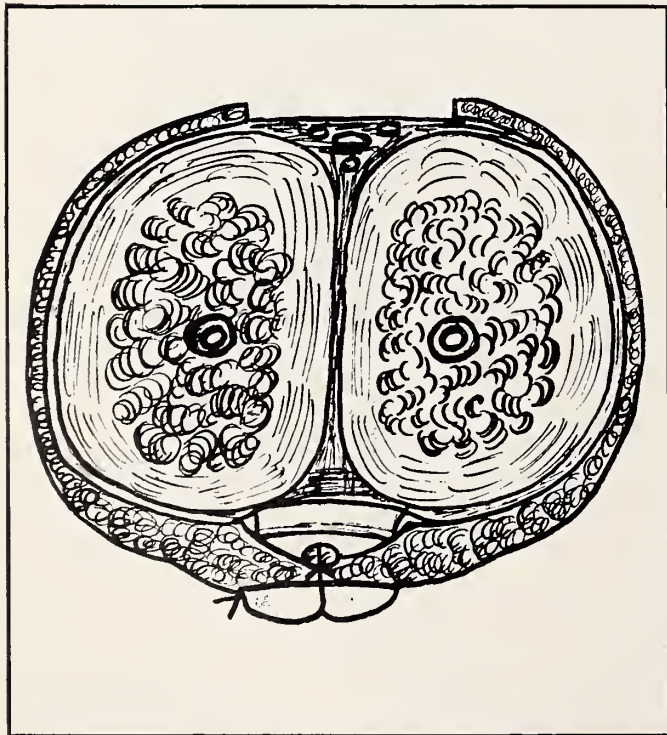


Figure 3

A cross section of the penis illustrates the position of the epithelial strip which will form the urethral channel.

outlined by the two longitudinal incisions is accomplished in two layers using 00000 atraumatic chromic catgut for both. The first layer consists of interrupted sutures taken through Buck's fascia on both sides with extreme care exercised to prevent any buttonhole effect in the epithelium as this is a likely source of fistulae. This approximates the flaps in the midline ventrally and covers the epithelial strip which becomes the nidus of the new urethra. This first layer of suture has the same effect as the elaborate stays used by Browne; and in our experience this has been more successful and far easier to apply. The second layer of closure consists of approximation of the epithelial edges of the lateral flaps with interrupted sutures. (Figure 2) (Figure 3) The closure is now complete, and its success or failure is dependent upon the next step which is a dorsal relaxing slit extending from the coronal sulcus to the skin over the pubis. The point of greatest constriction is the base of the penis, and a liberal dorsal slit is absolutely essential for primary healing in this area. (Figure 4) The penis is now fixed in the erect position by use of the tension suture through the glans. The genitalia are covered with sterile mechanics waste or similar material, and an elastic pair of pants are applied using tensor bandage.

Post-operatively, erections are effectively controlled by diethylstilbestrol which is first administered 24 hours prior to surgery. Except for removal of

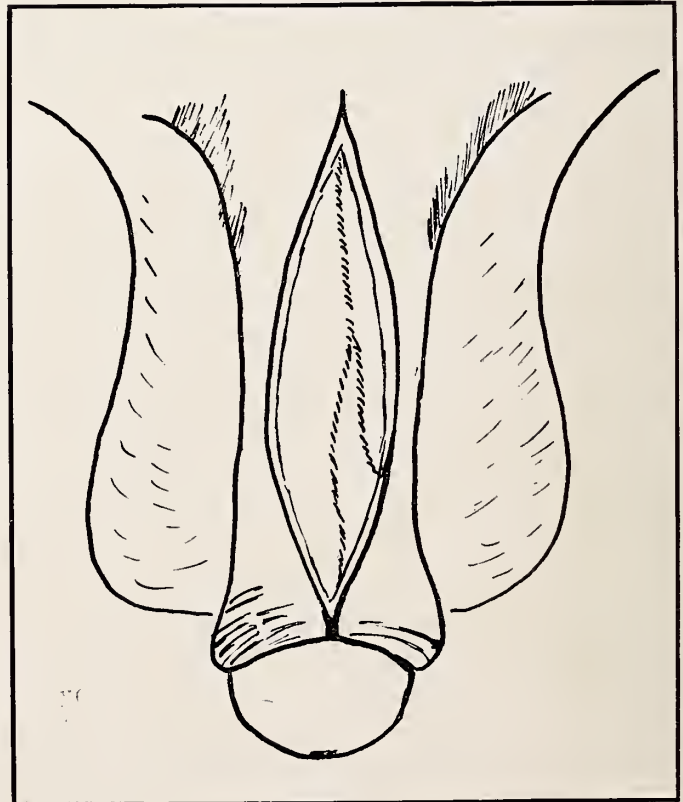


Figure 4

A dorsal relaxing slit of the extent illustrated above is necessary for primary healing of the ventral closure.

the drains, the operative area is not disturbed for five days, when the pressure dressing and tension suture are removed. Until the catheter is removed on the fourteenth day, infection is suppressed with penicillin and streptomycin.

The overall results reported by Browne⁶ are distinctly superior to those obtained by the use of other methods. My experience is relatively limited, but the simplicity of this procedure, the low incidence of complications, and the expectancy of complete repair in two stages of *all* degrees of hypospadias requiring surgery suggest its use in preference to other types of repairs. Two cases of pseudo-vaginal, one of peno-scrotal, one of penile hypospadias, and one of penile epispadias have been completed. The first case, one of pseudo-vaginal hypospadias, developed a small fistula where one subcutaneous suture button-holed the epithelium resulting in necrosis. This was closed and has not reopened. The remainder have been effectively reconstructed in two stages and have satisfactory urethras with no evidence of stricture.

Summary

A two stage method of repair of congenital chor-dee and hypospadias fundamentally the same as that developed by Denis Browne is presented with the hope that others will be encouraged to use this sound, relatively simple, effective solution to a distressing abnormality.

34 Seventh Street, N.E.

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New Members of the M. A. G.

<i>Name</i>	<i>Address</i>	<i>County Society</i>	<i>Classification</i>
Malcolm R. Hodges	Medical Arts Bldg., Macon	Bibb	Active
Henry K. Jarrett, Jr.	700 Spring St., Macon	Bibb	Active
Raymond A. Moody	3671 Houston Ave., Macon	Bibb	Active
Thomas E. Hamilton	1067 Banberry Rd., Marietta	Carroll-Douglas-Haralson	Active
William V. Crosby	428 N. Milledge, Athens	Clarke-Madison-Oconee	Active
Thomas A. Collings	Georgia Baptist Hospital, Atlanta	Fulton	Associate
James C. Crutcher	VA Hospital, Brookhaven	Fulton	Associate
Helen M. Denham	U.S.A.H., Ft. Jackson, S. C.	Fulton	Active
Tom W. Duke	Grace-N. Haven Hosp., N. Haven, Conn.	Fulton	Active
Jack Rawlings Free	Grady Memorial Hospital, Atlanta	Fulton	Associate
John T. Galambos	Grady Memorial Hospital, Atlanta	Fulton	Associate
Maxwell Felton Hall, Jr.	Emory Univ. Hosp., Emory University	Fulton	Associate
Stanley L. Peek, Jr.	1293 Peachtree St., N.E., Atlanta	Fulton	Active
John Albin Ward	Grady Memorial Hospital, Atlanta	Fulton	Associate
Robert E. Wells	384 Peachtree St., N.E., Atlanta	Fulton	Active
August S. Yochem, Jr.	478 Peachtree St., N.E., Atlanta	Fulton	Active
John H. Carswell	Hiawassee	Habersham	Active
Bingley L. Burdick	N. Patterson St., Valdosta	South Georgia	Active
Fred C. Smith	Valdosta	South Georgia	Active
Emory F. Thompson	400 W. Central Ave., Valdosta	South Georgia	Active
Paul H. Dietrich	48 E. View Dr., Chattanooga, Tenn.	Walker-Catoosa-Dade	Active
Robert T. Jones	LaFayette	Walker-Catoosa-Dade	Active

LOCAL ANESTHESIA-- A LOST ART?

SOME MONTHS AGO, an anesthesiologist was approached by a surgeon with the following query, "Will you handle Mrs. X in the morning, she's a rather difficult problem." The former consented readily (the operation was posted as the removal of a growth on the face.) Thinking that the growth was malignant and that possibly its removal was to be combined with a neck dissection, he thought little of the request. The patient in question turned out to be 84 years of age, she had been digitalized for the previous 18 years and was at best a very poor candidate for any type of surgery and an extremely poor anesthetic risk. On further inquiry, it was discovered that the excision of a small nevus was being done at the patient's insistence since she feared the development of cancer. The patient had not anticipated general anesthesia and was well pleased when she discovered that she did not have to go to sleep. The surgeon was somewhat abashed when the suggestion was made that local anesthesia be used. Under many circumstances the very best anesthesiologist is no substitute for a properly administered local anesthetic. Yet in the past 25 years, surgeons have been "slipping away" from the use of local anesthesia, some even reaching the point of apparently forgetting that local agents exist.

The primary reason for the abandonment of local anesthetic procedures has been the lack in teaching proper techniques for handling these drugs. How many residents in surgery are taught how to do an inguinal hernioplasty or remove a thyroid nodule under local anesthesia? Very few learn the proper method of using novocaine for the suturing of a laceration, much less its use in removing an appendix. Yet many of these same residents will practice surgery in areas where the passage of an endotracheal tube is a major procedure, and where vomiting during anesthesia will constitute almost certain death for the patient. Life has been sacrificed many times for lack of this knowledge, and the death that occurs is laid at the feet of the hapless individual who administered the anesthetic. With the advent of hospitalization insurance, many operations formerly done in the office are now done in the operating suite. Hand in hand with this change has come the use of general anesthesia for operations which for

many years had been done under local anesthesia. Patients have demanded general anesthesia in many instances, but more often the surgeon prefers the quick, easy, "little bit of pentothal" (a myth) to the somewhat slower, even though safer, small amount of novocain.

Granted, there are reactions to local anesthetic drugs. These fall into two categories. The first manifests itself through the signs of central nervous system stimulation, with an increased pulse rate, sweating, agitation, mental confusion, twitchings; and it progresses in its severest form to convulsions which kill through the medium of hypoxia due to inadequate respiratory exchange. The second is the anaphylactic reaction with sudden cessation of cardiac and respiratory activity. Fortunately, this second reaction is rare, since its treatment requires cardiac massage and a battery of care not readily available even in many operating rooms. The convulsive reaction is readily amenable to treatment with an injectable (preferably ultra-short acting) barbiturate and the administration of oxygen. Facilities for treating this reaction should be always at hand, whether the local is given in the office or in the operating room, since there is no way to predict this reaction. Some of these can be prevented by the pre-operative administration of a short acting barbiturate (nembutal) 45 minutes to one hour before the injection of the anesthetic drug. Tests for sensitivity to the various local agents are unreliable and of no value. The best way to avoid reactions to these drugs is to use them in minimal but effective quantities, and to become skillful in their use. Large doses do not compensate for improper placement.

Cocaine was the first local anesthetic agent used, but it is now confined strictly to topical application. Its toxicity is high. Procaine (novocaine) has held sway as the safest injectable local drug, although pontocaine has a very satisfactory dosage/toxicity ratio when injected. Within the past five years, two other drugs have been introduced into this field, cyclaine and xylocaine. These have been well tested clinically and possess certain advantages. Xylocaine is superior to novocaine for infiltration and block anesthesia since it diffuses rapidly through tissue and establishes better and faster acting anesthesia. It also lasts longer than novocaine and is apparently less toxic. Cyclaine possesses the same advantages, but recently it has been shown to produce permanent tissue changes which are undesirable. However, cy-



claine is superior to cocaine in the production of topical anesthesia on mucous surfaces and offers a lower incidence of reactions as well as less prolonged and severe reactions. Space does not permit further definition of the properties of these two drugs, but their use is advised to anyone interested in better results from local techniques.

There are many occasions when there is no substitute for a good local anesthetic. One was cited above. The incarcerated inguinal or femoral hernia in an elderly patient is one of the most frequent occasions for its use in major surgery. Lifesaving it may be, since these patients are prone to vomit, aspirate, and succumb to the effects of anoxia under general anesthesia. The full stomach of pregnancy is no hazard when local anesthesia is used. The convenience of general anesthesia must be weighed against the safety of a well-conducted local procedure.

In days gone by, the best surgeons were those who knew most about anesthesia. The majority of the techniques for the production of local or block anesthesia were first described by surgeons, and only lately modified by anesthesiologists. With the relative paucity of trained anesthesiologists, it would behoove centers of medical teaching to concentrate a bit more on the teaching of proper use of local anesthetic agents. Perhaps it would be a good idea for every surgeon to review his choice of anesthesia a bit more critically, with a view toward increasing his knowledge of the proper use of these drugs.

ILLUSTRATIVE CASES NEW JOURNAL SECTION

IN THIS ISSUE the editors have included a new feature to be known as "Illustrative Cases." Members of the Medical Association of Georgia are cordially invited to submit cases for publication in this department of the *Journal*. These cases need not be rare or bizarre but should rather be interesting and instructive. Any case is acceptable for publication if it illustrates an important point in any branch of medicine or surgery. The editors want to provide a medium through which members may share with other physicians useful knowledge and experience gained from clinical cases. We believe that doctors are reluctant to publish cases unless they can present a carefully studied series of cases, and we hope that this department will help to overcome this reluctance. It is hoped that it will not only add to the interest of the *Journal* but will also encourage contributions from more physicians. It will be necessary to sub-

mit only the pertinent facts of the case. Each case will be discussed by one or more of our members who is an authority on that particular subject. For example, the case in the present issue on the milk and alkali syndrome has been discussed by Thomas Findley and Leland D. Stoddard. We shall be happy to receive your own case reports.

MENTAL HEALTH

MENTAL HEALTH is receiving the medical spotlight throughout the country today as a result of recent advances in methods of treatment and prevention of mental illness. In addition, there seems to be an increased social awareness of the part played by mental and emotional disturbances in the problems of poverty, crime, alcoholism, juvenile delinquency, etc.

Georgia physicians are now more than ever before cognizant of the fact that 11,790 people from the towns and homes of our state are at the present time patients suffering with mental illness in the Milledgeville State Hospital. This is the second largest state mental hospital in the world and its population is growing at the rate of approximately 400 per year.

Basic Principles

With the advent of new methods of treatment including psychotherapy and drugs, which offer greater hope for a cure in the early phases of the illness, certain basic principles need to be re-emphasized.

First of all, mental illness is a disease which possesses both constitutional, individual, and social factors. The importance of social and individual factors is being stressed more all the time.

Secondly, the social problems associated with mental illness have resulted in the development of laws providing for arrest, protection, custody, and finally treatment in state institutions.

This system has created an artificial separation between the patient and members of his family who are deeply concerned with his welfare. It has also resulted in the public attitude that custodial treatment in state institutions is the most usual treatment for mental illness.

Early Treatment

With the development in general hospitals of psychiatric wards where patients can receive treatment within their home community, there has arisen increased emphasis on intensive treatment of mental illness in the early phases. The development of better understanding of mental illness has resulted in many patients' being treated without hospitalization by family physicians and by physicians trained in the field of psychiatry.

In a recent conference, Governor Griffin indicated that he considers the improved care and treatment

of mentally ill persons in Georgia to be on his priority list for 1955 and 1956. The Medical Association of Georgia congratulates the Governor for his interest in this important matter and will welcome the opportunity to confer with the Governor and his advisors in developing this state program.

MAG Committee

The MAG Committee on Mental Health in its report in May recommended the establishment of a teaching center at Milledgeville for the purpose of training psychiatric residents, psychologists, psychiatric nurses, psychiatric social workers, and psychiatric aides. It was recommended that this teaching center be coordinated with the psychiatric training programs in the two medical schools.

The committee also recommended revision of present laws relating to commitment procedures for the mentally ill so that with legal safeguards such persons will receive protection and treatment without being treated as offenders and confined to jail before commitment.

There is increasing demand for information, leadership, and direction both from individuals and community groups. The general public looks to each of us as a physician to develop our own professional skill in order that we may provide this leadership. Each physician can keep abreast of advances in

psychiatric treatment, the need for and development of facilities to care for the mentally ill, and also the laws relating to commitment and treatment of mentally ill.

It is the responsibility of this association and of each physician individually to exert our best professional effort toward providing leadership in the field of mental health and professional services to the mentally ill. The Committee on Mental Health of MAG is presently engaged in recommendations to promote these aims.

SCIENTIFIC EXHIBITS

THE SCIENTIFIC EXHIBITS COMMITTEE of the Medical Association of Georgia extends to you an invitation to present an exhibit at the annual meeting in Atlanta May 13-16, 1956. On the yellow page in the front of this *Journal* you will find an application blank for exhibit space which you can fill in and forward to the headquarters office of the Medical Association of Georgia.

The committee is anxious to make the scientific exhibits section an outstanding feature of the forthcoming meeting. Exhibits along the line of clinical investigation will be as welcome as those of a research nature. If you have a pet project which you feel will be informative to the physicians of Georgia, fill in the blank and send it along. Applications will be reviewed in the chronological order in which they are submitted.

Southern Medical Association to Meet

THE SOUTHERN MEDICAL ASSOCIATION, the nation's second largest general medical organization, will hold its 49th Annual Meeting in Houston, Texas, on November 14-17, 1955. More than 3,000 of the Association's 10,000 members are expected to attend the four-day meeting.

The Scientific Assembly of the Southern Medical Association is one of the nation's outstanding post graduate events for practicing physicians. The intensive work of the Scientific Assembly will feature some 300 papers by outstanding researchers and practitioners in all of the major medical and surgical fields. The following sections will hold from one to three sessions: Anesthesiology, General Practice, Gastroenterology, Medicine, Surgery, Neurology and Psychiatry, Pathology, Proctology, Urology, Gynecology, Obstetrics, Public Health, Industrial Medicine

and Surgery, Pediatrics, Allergy, Radiology, Dermatology and Syphilology, Physical Medicine and Rehabilitation, Orthopedic and Traumatic Surgery, Ophthalmology and Otolaryngology. All of the scientific programs of the 20 sections will be presented in the various meeting rooms of the Shamrock Hotel.

In addition to the 20 sections of the Association, several other major specialty groups will meet conjointly. Among those planning programs in Houston are: American College of Chest Physicians—Southern Chapter, Association for Research in Ophthalmology, Southern Gynecological and Obstetrical Society, Women Physicians, and the Southern Society of Cancer Cytology.

The Association has a Housing Bureau, Box 1267, Houston, Texas, to which all requests for hotel accommodations should be addressed.

Oral Drug Therapy For Essential Hypertension

ALBERT A. BRUST, M.D., Atlanta, Ga.

THE PRACTICING PHYSICIAN, confronted by an imposing array of allegedly hypotensive agents and an equally imposing clientele of hypertensive patients finds himself frequently on the horns of a therapeutic dilemma. The questions he must weigh are numerous. Whom should I treat? Are there exact indications for the use of these drugs? Which drugs or combinations are best? What are the risks involved?

Wholly acceptable answers to these questions cannot yet be supplied. Clinical and research experience with most of the available agents cover only a three year period and have produced results which still must be considered contradictory, having engendered enthusiasm in some quarters, discouragement in others.

The Council on Pharmacy and Chemistry of the American Medical Association, taking cognizance of the problems posed for the practitioner by the disagreements over hypotensive drugs is actively working to clarify the situation. A recent symposium of those engaged in clinical drug research resulted in general agreement as to the dangers and risks involved in drug treatment but differences of opinion as to both immediate and long term net results to be expected from hypotensive therapy. The airing of these differences has resulted in the establishment of a committee with the assigned task of attempting some standardization of criteria for improved diagnosis and grading of the severity of individual cases. It is hoped that such standardization will make possible a more accurate comparison of results obtained in different clinical centers and the establishment of criteria by which new drugs can be judged more adequately and objectively.

Certainly most physicians are still inclined to reserve the most potent drugs for use in the most severe cases. As such, most patients with benign hypertension are being managed with varying combinations of reassurance, Rauwolfia preparations, or phenobarbital. Toxic effects of Rauwolfia are infrequent in the usual doses employed (0.5 to 1.0 mg, b.i.d.)

and although its depressor effects are largely attributable to its sedative properties, these are frequently desirable for the benign hypertensive.

In more severe and accelerated forms of the disease, more drastic therapeutic attempts seem justified. Surgical sympathectomy and low sodium regimens should not be forgotten in the present wave of enthusiasm for "medical sympathectomy."

Oral use of the more potent drugs deserves special comment, for, although the indications for their use are not clear cut, certain dangers and contraindications can now be pointed out. Hydrazinophthalazine used alone induces disappointing depressor effects, carries the threat of production of a lupus-like syndrome in high doses, and may precipitate angina and even failure by increasing the work of an already overburdened heart. The adverse cardiac effects appear to be reduced when the drug is employed in combination with either Rauwolfia or the methonium compounds.

The physician who is considering the use of any of the methonium compounds in his patient should weigh his decision carefully. His degree of success in employing these agents will hinge primarily upon his ability to obtain the fullest degree of patient cooperation. Several important considerations deserve emphasis.

True uremia in malignant essential hypertension has never been reversed by reduction of the blood pressure level. Indeed, some observers suggest that fatal uremia has been hastened by blood pressure lowering.

The risk of shocklike reactions on assumption of the erect position has not been sufficiently emphasized in patients suffering from malignant hypertension. The ability of the individual patient to survive these periods of sudden blood pressure fall appears to depend on the degree of involvement of the target organs, i.e. the brain, kidneys, and heart. In particular, patients with cerebral damage from strokes or encephalopathy manifest curious sensitivity to ganglionic block resulting in vascular collapse. An

interstitial pneumonia apparently resulting from the use of hexamethonium has proved fatal in some cases. The side effects of constipation, dry mouth, sexual impotence, and visual difficulties though less dangerous are serious deterrents to adequate patient cooperation. The use of Rauwolfia in conjunction with methonium compounds may be of help in reducing some of these disturbing side actions.

Thus in the absence of any single widely effective agent which can smoothly reduce an elevated blood

pressure without producing multiple side hazards to the patient, the physician must exercise caution in selection of therapy. No "rules of thumb" are currently proper.

The best procedure at present would seem to be to individualize the treatment on the basis of the severity and rapidity of progression of the hypertension as revealed by careful diagnostic studies, reserving the more drastic and complicated drug regimens for those most imminently threatened by their disease.

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.

Ain't Got Time by



C. F. Holton, M.D.

Ain't got time to go a-fishing
Ain't got time to relax
Ain't got time to sit a-wishing
Got to pay my income tax.

Ain't got time for my family
Hardly know the children's names
Ain't got time to sit and listen
To their tales of childish games.

Ain't got time to romp and play
Ain't got time to go to church
Got to work 14 hours every day
Can't leave my business in the lurch.

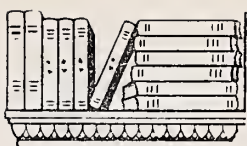
Ain't got time for mirth or laughter
Ain't got time to take a drink.
Ain't got time for the hereafter
Ain't got time to sit and think.

Ain't got time to hit a golf ball
Ain't got time to sink a putt.
Got to give my very all
To keep the wolf from my hut.

Ain't got time for a vacation
That's all foolishness anyway.
I can get my recreation
Doing things that bring in pay.

Ain't no one can take my place
Ain't got time for story or fable.
Think I'll have to step up my pace
Got to make it while I'm able.

Ain't got—GOOD MORNING GABRIEL.



BOOKS RECEIVED

Reed, Sheldon C., *Counseling in Medical Genetics*, W. B. Saunders Company, Philadelphia, 1955, 268 pp., \$4.00.

REVIEWS

Larsson, Tage and Sjoegren, Torsten; **A METHODOLOGICAL, PSYCHIATRIC AND STATISTICAL STUDY OF A LARGE SWEDISH RURAL POPULATION**, Ejnar Munksgaard, Copenhagen, 1954, 250 pages.

In spite of its formidable title, this book is an example of a new trend in the growth of psychiatry. Few psychiatric clinicians are aware of the significance attached to the work in biostatistics and the growing implications of genetic studies and sociologic studies of emotional illnesses, although we are all aware of statistical methods in such things as the relationship between smoking and lung cancer.

The study is significant mainly for its excellent example of research design. In a discreet isolated population group of 25,000 people, records for 45 years have been compiled and means devised for deriving significant conclusions. A large part of the book is devoted to a description of the methodology and the rationale for each step. "Expectation" rates for mental illness, severe mental deficiencies (I.Q. under 55), and even suicides are formulated. This type report utilizes a unique terminology so that reading the body of the book is not easy, but certain parts are very interesting and the summary chapter is direct and clear-cut.

The data itself is of importance. In the 25,000 there are approximately 800 psychotic persons, 60 psychopathic personalities, 300 severe mental defectives. Detailed data about the psychiatric diagnosis of the percentages of various categories is not remarkable. A report on the 116 suicides illustrates one of the problems in trying to carry over the data to our population. Forty-five of 116 killed themselves by hanging. This is more usual in a rural population and much less frequent in the United States, where poisoning is the usual weapon. This data is very similar to N. A. M. H. rates for the U. S. A.—six per cent mentally, and one suicide per 10,000 population each year.

Of the psychotic patients still living 33 per cent are in the hospital. The average hospital duration is 5.1 years with 17 per cent in the hospital 10 plus years and six per cent 20 plus years. This is quite encouraging in terms of the usual idea about the percentage of recovery from state hospital commitment.

Interestingly enough, they find a diagnosis of epilepsy tenable in only four per cent of the mentally defective, which is in contrast with the usual idea of the concurrence of these two conditions. They also conclude that consanguinous marriages, first cousin or closer, do not predispose to psychosis but do seem to predispose to mental deficiency.

It is hoped that this book may stimulate the public health services or others interested in over-all mental health problems to develop such a study of our population. Its results would make community planning and public health programs more practical.

Carl A. Whitaker, M.D.

Martin, Gustav J., Sc.D., **ION EXCHANGE AND ABSORPTION AGENTS IN MEDICINE, THE CONCEPT OF INTESTINAL BIONOMICS**, Little, Brown and Company, Boston, 1955, 333 pp., 36 illustrations, \$7.50.

The author, Research Director of the National Drug Company of Philadelphia, states in his preface that, "It is my contention, as yet unsubstantiated by clinical observations, that all chronic degenerative disease has as an important component in its etiology the absorption from the intestine of small quantities of toxic chemicals. These agents produce imperceptible but irreversible changes in tissues and in the course of years create gross pathology. I believe that the absorption of these toxic agents can be prevented by proper selection of ion exchange and absorption materials." The portions of this book dealing with the utilization of these materials as adjuncts in the management of peptic ulcer, diarrhea, and other gastro-intestinal disturbances are not very convincing. The chapter which describes the more familiar use of cation-exchange resins for the purpose of removing sodium or potassium from the body seems reasonably complete, but most physicians have been disappointed with bedside results. The chapters describing the chemistry of these interesting substances which are finding increasing usefulness in industry and biology seem authoritative enough, and chelating agents are briefly but optimistically reviewed. There is an account of such standard remedies as charcoal, kaolin, bismuth, and other intestinal absorbents. If he were still alive, Dr. Metchnikoff would certainly approve the final chapter entitled "The Concept of Intestinal Bionomics", a philosophical attempt to attribute degenerative diseases of all kinds to the metabolic activity of intestinal bacteria.

Thomas Findley, M.D.

Albritton, Errett C., A.B., M.D. (Editor), **STANDARD VALUES IN NUTRITION AND METABOLISM**, W. B. Saunders Company, Philadelphia, 1954, 380 pp., \$6.50.

This handbook of 380 pages (8½ x 11 in.) is the second in a series of compilations of basic biological data prepared under sponsorship of the Wright Air Development Center, U. S. Air Force, by contract with the National Academy of Sciences-National Research Council. Direction of the work was entrusted to a committee of 24 members representing major fields in plant and animal biology, but the gigantic task of amassing and critically selecting the information comprised in the 145 tables and 15 diagrams was accomplished in collaboration with over 800 contributors and reviewers in this country and abroad. The tabulated and diagrammed material, which takes up two-thirds of the monograph, is to a large extent quantitative, and is organized under 13 categories. The first eight sections deal with such aspects of nutrients for various species of animals and plants, including microorganisms, as occurrence, stability, utilization, biological effects of deprivation, and of excess, food value, requirements for these, etc.; the type of information ranges from composition of balanced salt solutions and culture media to data of average yields and derived values of various food crops per acre of land. Sections VIII and IX are concerned with metabolic pathways and end products of metabolism; sections XI and XII, with respiratory data for tissues and organisms; and the last section, with energy exchange. As can be surmised, neither the tabulated forms nor the schematic diagrams are simple, but remarkable clarity of presentation has nevertheless been achieved in the presentation of this vast amount of information which can be readily found thanks to the comprehensive index of over 13 tri-columned pages. Dr. Albritton and his editorial staff have also accomplished a remarkable feat in the painstaking preparation of the elaborate bibliography which is a separate chapter covering more than 100 pages with fine print and arranged so as to give all references to individual values and items of information for each of the 160 charts.

Evangeline Papageorge, Ph.D.

Fulton, John F., M.D. (Editor), **A TEXTBOOK OF PHYSIOLOGY, SEVENTEENTH EDITION**, W. B. Saunders Company, Philadelphia, 1955, 1,275 pp., \$13.50.

In the half century since the *Textbook of Physiology* was first published, successive editions have kept pace with the new developments in that field. Now as continuing growth and further applications of physiology are occurring in the United States and Canada, the 17th Edition of *Textbook of Physiology* embraces the progress made to date.

Dr. John Fulton, the editor, and 29 contributors have compiled 1,251 pages of salient principles of

physiology. Although at first glance the format may appear objectionable, a little indulgence in the text quickly disperses this impression.

The value of the book is ably enhanced by figures, tables, and photographs. Excellent references, numerically indicated in the text, appear at the end of each chapter.

Fortunately for the reader, the text encompasses the necessary chemical changes associated in physiological processes, rather than divorcing them into the separate state of biochemistry.

The chapters devoted to endocrine glands will be a source of valuable, ready reference to those in clinical fields, as will the chapter dealing with the pathophysiology of pain.

The index is concise and most suitable for easy reference by student, teacher, or clinician.

The editor has drawn heavily on the efforts of contributors in other basic sciences, as well as clinical medicine, to aid in the production of a superior textbook.

Patrick C. Shea, Jr., M.D.

Silver, Henry K., M.D.; C. Henry Kempe, M.D.; and Henry B. Bruyn, M.D.; **HANDBOOK OF PEDIATRICS**, Lange Medical Publications, Los Altos, California, 1955, 448 pp., \$3.00.

This is the latest of compact handbooks by Lange Medical Publications, others of which have been favorably received by practitioners and house officers in the past. The material is divided into sections the headings of which closely follow the chapters in the standard texts in pediatrics. As the authors say in their preface, the handbook is intended to supplement rather than to replace the more complete pediatric text and, as stated, the concise format tends towards over-simplification. However, the material presented is accurate, and extensive use has been made of tables and diagrams.

The material is presented in outline form inasmuch as possible. However, when more explanation or discussion is warranted, it is included so that this book does not fall into the outline notebook category.

This book is very compact and complete, covering more concisely practically all of the topics included in the larger textbooks. However, this has been accomplished only at the expense of detailed discussion and not of fundamental accuracy.

It would seem that this handbook would be more useful to the graduate house physician and practitioner rather than the medical student whose problem is not one of quick reference but of more detailed leisurely study.

This handbook should find a very wide use within the limits for which it was intended.

George Erwin, M.D.



doctor placement page

NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

AVAILABLE PHYSICIANS

Anthony, James E., Jr., M.D., Presbyterian Hospital, 1753 West Congress St., Chicago 12, Illinois—Age 32; married; Methodist; graduate University of Maryland, 1947; residency Jefferson Hospital, Roanoke, Va.; Emory University Hospital, Atlanta; Presbyterian Hospital, Chicago, Ill.; specialty surgery; available June 1957.

Archibald, Donald Harper, M.D., 15 McElaney Drive, Black Pt. Road, Niantic, Connecticut—Age 55; married; Presbyterian; graduate Dalhousie University, Halifax, N. S., 1936; residency (Pathology) St. Vincent's Hospital, New York City, two years; Assistant Surgeon, St. Anne's DVA Hospital, Montreal, 2½ years; available now.

Calkins, Robert S., M.D., 8983 Mission Boulevard, Riverside, Calif.—Age 36; married; Presbyterian; graduate Oklahoma University, 1947; residency Presbyterian Hospital, Philadelphia, Pa.; specialty O. B. Gyn; available now.

Damron, John R., M.D., 216 Pearl St., Jackson, Ohio—Age 30; married; two children; Methodist; graduate University of Louisville, 1952; residency intern St. Vincent's Hospital, Toledo, Ohio. Interested in general practice in community of 8,000 or larger. Available now.

Hughes, Robert Rule, M.D., 18th Tac Hospital, APO 239, San Francisco, Calif.—Age 27; single, graduate University of Tennessee, 1952; will be released from service and desires 2-3 years work prior to residency; available May or June, 1956.

Mason, Roscoe E., M.D., Surgical Service U. S. Army Hospital, Fort Bragg, North Carolina—Age 32; married; Methodist, graduate Harvard Medical School, 1948; residency Boston City Hospital 13 months remainder including chief residency at Tripler General Hospital (U. S. Army) Oahu, T. H.; expect to be discharged August 1, 1955; available 1-15 August, 1955.

Payne, Woodrow, M.D., 764 McConnell, Memphis, Tenn.—Age 34; married; protestant; graduate University of Tennessee, 1944; 2½ years practice in urology. Primary interest in individual practice in city of 20,000 to 75,000 population; will consider group, purchasing an established

practice, or partnership in aforementioned size city.

Yingling, Nathaniel D., M.D., Thayer Veterans Hospital, White Bridge Road, Nashville 5, Tenn.—Age 32; married; Methodist; graduate Jefferson Medical College, Philadelphia, Pa., 1947; residency three years preceptorship at Clearfield Hospital, Clearfield, Pa.; two years approved by American Board of Surgeons. Will complete Board requirements at Thayer V. A. Hospital residency July 1, 1956. Available August 16, 1955.

AVAILABLE LOCATIONS

Arlington, Georgia (Calhoun County)—Population 1,382. In need of doctor-surgeon for practice in new excellently equipped 16-bed hospital, located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia.

Atlanta, Georgia (Fulton County)—Needed immediately, young man doing general medicine interested in association with established X-Ray and clinical laboratories. Contact: Drs. Landham & Klugh, 736 Piedmont Avenue, N.E., Atlanta, Georgia.

Braselton, Georgia (Jackson County)—Doctor must now come from one of following places; Jefferson, 10 miles; Winder, 10 miles; Lawrenceville, 20 miles; Gainesville, 20 miles; Buford, 20 miles. Have a well equipped clinic and a home rent free. Clinic is rent free and home until doctor can afford to pay rent or buy a home. Possible that home will be furnished free.

Broxton, Georgia (Coffee County)—Population 3,500—Doctors clinic available; also home available; 60 room county hospital at Douglas; seven room doctors building; no physician in area; physician will have more work than he can do. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia.

Dillard, Georgia (Rabun County)—Population 2,500. Doctor's office to be furnished rent free for one year; would rent five or six room house, fully equipped kitchen, county hospital at Clayton; drug store and pharmacist; good schools; doctor would be welcome right now; late doctor had an excellent practice; other benefits considered in a short time; active church groups and community club that would be happy to assist doctor. Contact: Mrs. L. Neville, Dillard, Georgia.

Hampton, Georgia (Henry County)—Population 1,000—No doctor in Hampton, nearest 10 miles away; hospital in Griffin; office space, housing available; contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia.

Jeffersonville, Georgia (Twiggs County)—One physician in area doing limited practice; hospital facilities nearby in Macon; office space available with small rental or purchase; one drug store with registered pharmacist; house made available immediately; 69 lakes stocked with bass brim or trout; 150,000 acres woodland makes Twiggs County good hunting ground for small game; definite need for physician. Contact: Mr. H. C. Swearingen, Jeffersonville, Georgia.

Smithville, Georgia (Lee County)—Population 700—No physician in area; home in Leesburg, office downtown rent free; completely equipped office of two rooms and connecting lavatory with outlets for sterilizers, etc., attached. All Contact: Mr. E. H. Conner, Unadilla, Georgia.

Snellville, Georgia (Gwinnett County)—Population 500, area 5,000. No physicians in area; hospital facilities in surrounding area, Atlanta, Stone Mountain, Buford, and Duluth; new office and home, stone building; new \$216,000.00 high school started in September 1955; new Baptist and Methodist Church buildings. Contact: Mr. Ralph Head, Snellville, Georgia.

Unadilla, Georgia (Dooly County)—Population 1,200—Dooly County Hospital owned and operated by the people of the county; office space available or will build small clinic and let doctor rent or buy. Housing will be provided rent reasonable or can get house built to suit. They guarantee a good doctor will do well; one physician in area, age 75.

Woodbine, Georgia (Camden County)—Population 1,000. Small, fully equipped office and clinic available; ample office space, delivery room, laboratory (inc. x-ray), nursery, wards, private rooms; five room wooden dwelling adjoins hospital available at \$35.00 mo.; one other doctor in Woodbine, doctor is needed now. Contact: Dr. S. C. Atkinson, Waverley, Ga.

U. S. Civil Service Commission, Board of Civil Service Examiners, (Occupational Medicine), GA-12, \$7,040 per annum. This position requires one year of occupational medicine experience beyond and approved rotating internship. No minimum age limit.

please notify . . .

Medical Association of Georgia
875 West Peachtree Street, N. E.
Atlanta, Georgia

. . . when a location has been filled

abstracts by georgia authors



Rieser, Charles, 819 Cypress St., N. E., Atlanta, Ga. "Masses in the Scrotum: Problems in Their Diagnosis", *Sou. Med. J.* 48:627-631 (June) 1955.

The multitude of pathologic conditions concerning the scrotum and its contents are mentioned. The importance of detailed history indicating mode of onset, character and severity of pain, and duration of disease afford pertinent clues toward the diagnosis. Limitations by inaccuracies of the patient's impressions should be realized. Physical evaluation should follow the time honored routine of inspection and palpation. Inspection in both supine and upright positions proves helpful, taking particular note of change in contour of the scrotal mass, color and character of the skin. Palpation reveals weightiness, differentiation and gross characteristics of epididymis, testicle and cord structures. Injection of novocain into the cord permits leisurely palpation in an otherwise painful examination as in torsion. Additional facts can sometimes be gleaned by rectal digital appraisal, as in tuberculosis of both prostate and epididymis. Aspiration of an hydrocele permits better feel of a testicle so necessary in excluding tumor. Systemic manifestations of pyogenic infections, tuberculosis, medical conditions such as mumps, cardiac failure, or nephritis with edema of scrotum, tumors of the testis assist in the final evaluation of the mass. Laboratory studies such as chest x-ray, excretory urography, hormone content of the urine, radio-active phosphorus taken up by the testis lend assistance. Exploration in doubtful cases is indicated because of the extreme seriousness of procrastination in the presence of tumor.

Arnold, Edwin T., 20 Commerce Street, Hogansville, Ga. "Sexual Maladjustment in Normal People", *Med. Times* 83:543-544 (June) 1955.

Two case histories are cited to emphasize the great need for education in sex at the high school level. There is just as much ignorance and misinformation as ever on this subject in spite of the subject's being discussed in every type magazine and book for the past few years.

There are pitfalls and room for much misunderstanding even at best in attempting this type instruction, but it seems reasonable that much of value could be taught to small groups of the same sex. If this is done it will save many people from much unhappiness and maladjustment in married life and make for better mental health on the part of the population.

Bryan, William W., M.D., and J. Frank Walker, M.D., 710 Peachtree St., N.E., Atlanta, Ga. "Radiologic Aspects of Pancreatic Fistulae", *Sou. Med. J.* 48:710-710 (July) 1955.

The adjunctive use of high voltage, heavy filtration x-ray therapy in the treatment of pancreatic fistulae has resulted in closure of these fistulae in a number of patients. We have treated five separate patients having copious pancreatic drainage and autolysis of the abdominal wall tissues from external pancreatic fistulae following operative procedures upon the pancreas. The distressing symptoms and fairly frequent debilitation of patients who have external pancreatic fistulae would merit consideration of x-ray therapy to cause temporary inhibition of the external pancreatic secretion and depression of its enzymatic activity. The amount of x-radiation utilized in this type of treatment has not resulted in any untoward sequelae in the patients we have observed.

Robinson, David, M.D., and Jerome M. Vaeth, M.D., 104 East Taylor Street, Savannah, Ga. "Intravenous Urography", *AMA Arch. Surg.* 71:78-79 (July) 1955.

Although the iodide containing drugs used in intravenous urography are relatively safe, there are still reactions to these dyes which are distressing to both the patient and physician. A review of the literature reveals the recent use of antihistamine-like drugs in the prevention of these reactions.

Instead of an antihistamine-like drug, these authors used dimenhydrinate (Dramamine) which was administered intravenously as a premedication in 51 unselected cases for intravenous urography. There were also 51 unselected controls. The initial results for this series showed considerable decrease in the side-effects in the premedicated group; whereas, in the un-premedicated group, reactions occurred in about 20 per cent. There was also noted an apparent improvement in the resulting roentgenogram due to a decrease in the airswallowing.

Lanni, Frank, and Yvonne Thery Lanni, Dept. of Bacteriology, Emory University School of Medicine, Emory University, Ga. "Influenza Virus as Enzyme: Mode of Action against Inhibitory Mucoprotein from Egg White", *Virology* 1:40-57 (May) 1955.

The enzymatic inactivation of inhibitor by swine influenza virus was studied at pH 7.2-7.3 and 26 C. Complex formation appears to be mediated mainly by electrostatic forces, since most virus-inhibitor collisions result in combination. An infinitesimal fraction (less than 10^{-10} of the complexes existing at any moment possess the energy needed for substrate activation. However, the attractive forces are sufficiently strong to stabilize the complex until the requisite energy is delivered to the susceptible bonds, probably through rapid local fluctuations. Although very few of the attached substrate molecules dissociate and diffuse away in the unaltered state, some, and possibly a large fraction, diffuse away before inactivation is complete. These partially altered molecules possess reduced affinity for virus. Together with the probable reversible aggregation of inhibitor at high concentration, they account for certain striking anomalies in the inhibitory behavior of partially inactivated inhibitor preparations. The results support the concept that the substrate molecule contains a large number of distinct virus-receptors (Gottschalk), each of which can be modified independently.

Arnold, Edwin T., M.D., 20 Commerce St., Hogansville, Ga. "Thorazine in Obstetric Cases," *Med. Times* 83:707-708 (July) 1955.

Oral "Thorazine" in 25 to 50 MG doses early in labor has a definite beneficial effect on the mother in that it induces a good degree of tranquility in nearly every case in sometimes a remarkable degree. A much smaller dose of the other commonly used analgesic agents is adequate when used with Thorazine. I have observed no disadvantages and encountered no complications in the use of this agent along with Demerol, Scopolamine, Morphine and N20 & O2.

In most cases, 25 to 50 MG Thorazine followed by 50 MG Demerol and 1/150 gr. Scopolamine subcut. produces very adequate analgesia and amnesia. Only a very little N20 & O2 is needed for delivery, even in forceps and breeches.

In long labor 1/12 gr. morphine may be added every four hours along with 10 to 25 MG oral doses of Thorazine. The original report was based on 13 cases. This series has now been extended to 60 or 70.

Attention--For Hemophiliacs

MR. JIMMIE A. MILLER, 240 Newcastle Street, Brunswick, Georgia, is interested in hearing from patients or parents of patients who have hemophilia. He thinks that perhaps this group would be interested in organizing an association to promote research and study of this

disease.

If you have patients with this disease, please give them this information so that they may write Mr. Miller if they would like to join in this effort.

Reply of MAG Secretary to J. C. Metts

Re: Eugene Talmadge Memorial Hospital

Dr. James C. Metts
110 West Gaston Street
Savannah, Georgia

September 14, 1955

Dear Jim:

Thank you for your letter of August 23. It is good to know that men of your caliber are seriously interested in the situation at Augusta, because the problem vitally concerns the future practice of medicine in Georgia.

Please rest assured at once that the Council of the Medical Association of Georgia has never considered the first proposal of any type that slightly resembles retaliation or vituperation against the Medical College or the Talmadge Hospital or any member of the faculty. It can be truthfully said that Council has slowly and tediously explored every possible avenue of conciliation and, in fact, has made all the overtures in this direction up to now. Actually Council has no authority to do anything except to support the Richmond County Medical Society which likewise has not even threatened any action against faculty members who participate in the program. I feel sure that you would be agreeably surprised to know that most if not all members of the state Association are sincerely anxious to support the Medical College, or at least they want nothing done to hurt the school or jeopardize its standing. Thinking men realize that we need more good medical schools and will fight for and not against the two we have in Georgia.

But medical schools have responsibilities, too, both to their own alumni and to the other physicians in the state. If their educational mission can be accomplished as well by using charity and hospital-pay patients, then why this violent insistence upon including full pay patients in their program? All of a sudden it would seem that all teaching diseases had disappeared from poor people, and now pay patients must be brought in for instruction of the modern medical student. Most of us never saw a pay patient in our student, intern, and residency years; you have already assessed the excellent value of your own medical education and mine was also of very high quality.

As the conscientious physician studies the problems involved in this controversy he finds that confusion has been caused by attempting to place the entire matter on a personal basis, rather than considering the real issues involved. You must realize that decisions made in one tax supported hospital will inevitably open the doors for every similar hospital in Georgia, including your own new hospital in Savannah, to follow the identical policies without showing the need for such.

The Association has rightly steered away from the consideration of anything but the principles involved, and I believe you will agree that in the long run that is the correct policy.

The *Journal* has actually published very little concerning the vast amount of interest in this problem and has always attempted to be factual and without prejudice. We think our members should learn the complete facts so their decisions can be made intelligently and with a clear conception of what is right and wrong in the matter. Certainly none of us would tell our Boy Scout sons that a little stealing is all right, even if the leader tells them to do it for a good cause.

The doctors in Georgia stand willing and ready to help the Medical College of Georgia and the Talmadge Memorial Hospital if they really want support. If they do, the entire problem can easily and readily be resolved to the advantage of everyone. Well-meaning alumni want to be loyal to their schools, and in turn our schools should carry on as they have in the past and not make radical departures from established custom.

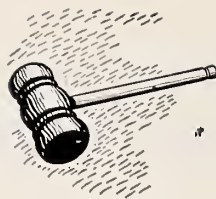
I appreciate the value that you place on my position, and I can personally assure you and all Georgia Alumni that I will work as long and as hard as the officials of the Medical College and the hospital in bringing about a fair and just solution. Perhaps you will be kind enough to make a request to those men in authority in Augusta, and they will find the Association ready and anxious to meet them more than half way.

Sincerely fraternally,

DAVID HENRY POER, M.D.
Secretary-Treasurer

This letter is in reply to a letter from J. C. Metts which was published on page 450 of the September issue of the *Journal*.

president's page



FARM-CITY WEEK, October 23-29, is truly a challenge to medical public relations. This is the second year that the AMA has participated in this gesture of good will and mutual understanding between the people of the country and town or city.

The greatest leaders of industry and the professions along with organized agriculture are going all out in promoting civic cooperation and making this a week of nation-wide activity in good citizenship. The programs proposed by the AMA's Council on Rural Health that should offer special opportunities in service from the physicians are: Child Welfare Program, Budgeting for Hospital and Medical Expenses, Rural Sanitation, Mental Health, Nutrition, Effects of Soil on Human and Animal Nutrition, Physicians for Rural Areas, Animal Diseases Related to Humans, Preventive Medicine, and Health Programs of the Land Grant Colleges' extension service to the 4-H Clubs, FFA, FHM's and the Boy and Girl Scouts and all other youth groups.

To the county medical societies it offers opportunity to exercise civic leadership, dramatize medicine's services, win support for community health programs, and enjoy reciprocal benefits of a major public relations program. The professions as well as industry may also reaffirm with some humility that all of our efforts to improve human welfare are secondary to our dependence on the farm for sustenance.

Four thousand Kiwanis Clubs are to mediate this program. It is my earnest hope that every county medical society has made known to its local Kiwanis Club its enthusiastic support of Farm-City Week.

H. D. Allen, Jr.

MAG Council Meeting

Sept. 11, 1955, Milledgeville, Ga.

J. W. CHAMBERS, LaGrange, chairman of council, called the regular meeting of the Council of the Medical Association of Georgia to order at 9:30 a.m., September 11, 1955, in the Baldwin County Health Center, Milledgeville, Georgia.

The following members of Council were present: H. Dawson Allen, Milledgeville, president; Hal M. Davison, Atlanta, president-elect; R. C. McGahee, Augusta, first vice-president; Stephen W. Brown, Augusta, second vice-president; David Henry Poer, Atlanta, secretary; Councilors: Lee Howard, Savannah, First District; George R. Dillinger, Thomasville, Second District; W. G. Elliott, Cuthbert, Third District; J. W. Chambers, LaGrange, Fourth District; Mark S. Dougherty, Jr., Atlanta, Fifth District; Henry H. Tift, Macon, Sixth District; D. Lloyd Wood, Dalton, Seventh District; Neal F. Yeomans, Waycross, Eighth District; W. Bruce Schaefer, Toccoa, Ninth District; and H. L. Cheves, Union Point, Tenth District. Vice-councilors present included: Charles T. Brown, Guyton, First District; Clarence B. Palmer, Covington, Fourth District; J. G. McDaniel, Atlanta, Fifth District; and J. Victor Roule, Augusta, Tenth District. AMA Delegates present were: C. H. Richardson, Sr., Macon; Eustace A. Allen, Atlanta; and Spencer Kirkland, Atlanta. Also present were Edgar Woody, Jr., Atlanta, *MAG Journal* Editor; Mr. Milton D. Krueger, Atlanta, MAG Executive Secretary; and Mr. John Kiser, Atlanta, MAG Assistant Executive Secretary.

Council Chairman Chambers delivered the invocation.

Chairman Chambers then called on Mr. Krueger for the minutes of the Council meeting Sunday, May 29, 1955; the called meeting of Council June 7, 1955; the conference phone call of the Executive Committee of Council June 16, 1955; and the minutes of the meeting of the Council of July 14, 1955. On motion made by Dr. Schaefer and duly seconded, the minutes for the May 29, 1955, meeting of the Council; the June 7, 1955 called meeting of Council; and the June 16 conference phone call of the Executive Committee of Council were approved. The minutes of the July 14, 1955, Meeting of Council were then read in full, and, on motion made by Dr. McGahee and duly seconded, these minutes were approved as read.

I. Secretary Poer spoke briefly on the Council's Executive Committee's function and responsibility. He recommended that the Executive Committee of Council meet monthly to transact the business of the Association. He also emphasized the importance of the Officers and Councilors, when speaking for the Association, to first check with the headquarters office. It was recommended that all press releases be made through the Headquarters Office for continuity and unanimity.

II. Chairman Chambers then called on W. G. Elliott, Chairman of the Council Reserve Fund Committee, and Dr. Poer, MAG Secretary. Dr. Elliott reported on a meeting held with Trust Company of Georgia Representatives. Dr. Poer stated that this matter is a con-

tinuing study and another report would be given at the December Meeting of Council for the Councilors' approval. On the general recommendation of the Council it was decided that this Reserve Fund Committee should also investigate all material relating to the inauguration of a Medical Association of Georgia Foundation. The purpose of this foundation would be to aid and assist MAG members in distress, financial hardships, and/or junior and senior medical students seeking financial assistance.

III. Chairman Chambers then called on Bruce Schaefer, Chairman of the Council Audit & Appropriations Committee, for a report of that committee. Dr. Schaefer reported that at the present time there were 2,200 paid members in the Association, this is an increase in the amount of dues collected for the fiscal year 1955. He also reported that disbursements were approximately normal for the three quarter period of September 1, 1955. Dr. Schaefer reported on the recent flood damage and estimated that approximately \$1,200 would be spent in replacing, repairing, and buying new supplies and equipment. Dr. Schaefer then brought up the recommendation of the Headquarters Office concerning a new addressograph machine. On motion (Schaefer-Dillinger) it was recommended that the purchase of a new addressograph machine for the Headquarters Office be authorized and that the cost run approximately \$1,200 which would include plates, etc. The motion was unanimously approved.

IV. Mr. Kiser presented a report concerning the "cultist" problem in Georgia. On motion made by Dr. Poer and duly seconded, it was recommended that the Chairman of Council appoint a committee of not less than three members of Council to investigate this matter further and report back to the Council at the next meeting. This motion was unanimously approved.

V. Mr. Krueger presented "MAG Biographical and Application for Membership Data" forms and recommended that the use of these forms be instituted. It was moved (Wood-Cheves) that these forms be gotten immediately and retained in the Headquarters Office with a copy for the county society secretary. The motion was approved.

VI. Mr. Krueger then presented to the Council the matter of the placement of a marble bust of Crawford W. Long in Georgia's Hall of Fame. He reviewed previous Council action (May 29) concerning this matter: "It was recommended that the Association approve the placement of a bust of Dr. Crawford W. Long for the Capitol Building. This motion was passed unanimously." Further investigation showed that the financial responsibility would, in the plan outlined by Mrs. Ernest R. Harris, be assumed by the Association. There being no specific fund for this allocation it was moved (Yeomans-Wood) that the matter be turned over to the Crawford W. Long Memorial Committee for further study. This motion was approved.

VII. (a) Mr. Kiser presented two communications from the Georgia Association of Pathologists. Item One concerned the Georgia Association of Blood Banks and their standardization of procedures and their further organization and improvement. It was the unanimous recommendation of Council that this movement be endorsed and supported by the Association. It was further recommended that this information be turned over to the Committee on Blood Banks.

VII. (b) Item Two concerned information supplied by the Georgia Association of Pathologists pertaining to lay technicians' encroaching on certain medical fields. The Georgia Association of Pathologists requested:

(1) that the Association inform and instruct delegates to oppose the certification of laymen in these areas and;

(2) that the Association reaffirm that the practice of pathology be limited to M.D.'s only. On motion (Yeomans-Dougherty) it was recommended that the MAG oppose the certification of lay people in this connection and that the MAG delegates and MAG members be so informed as to make their opinions felt in the AMA. This motion was approved.

VIII. Mr. Krueger gave a report of progress on the 1956 Annual Session as arranged by the Scientific Work Committee in conjunction with the Local Arrangements Committee and the specialty society program chairmen.

IX. David Henry Poer reported on the Sears Roebuck Foundation and its plans and programs for the State of Georgia. It was recommended that a form letter be sent to the intern staffs of the larger hospitals in Georgia to further publicize the Sears Roebuck Foundation. The report was rendered for information only and no action was requested.

X. Mr. Krueger asked the Councilors whether or not they wanted a personal notebook in which to keep all Council and MAG data. On motion (McGahee-Wood) the matter was approved and referred to the Audit and Appropriations Committee for appropriate study.

XI. The next item of business concerned the Eugene Talmadge Memorial Hospital Policy, and Chairman J. W. Chambers reported on a legal conference held with the Association attorney and MAG Secretary Poer. His report concerned a Council resolution requiring investigation into the legality of the present Talmadge Hospital's operational policies. The matter was fully discussed and there was no further action in this connection. On motion (Dillinger-Davison) it was approved that the Council endorse in principle a legislative revision of the "charges" that may be made for patients treated in the Talmadge Memorial Hospital under the present enabling act. Further, Council directed the Executive Committee to meet with the Legislative Committee to effect any changes that may be necessary in the enabling act to revise the operation of the Talmadge Hospital in an ethical and legal manner. This was passed unanimously.

The Council unanimously approved the appointment of the following representatives to attend a meeting of the AMA Council on Medical Services scheduled for September 18, 1955, Chicago. The meeting was called to consider reports from state medical associations presently having problems related to the unethical practice of medicine in connection with medical school hospitals. The MAG representatives appointed were R. C. McGahee, Augusta, and Stephen W. Brown, Augusta, chairman and co-chairman of the Talmadge Memorial Hospital Committee; Thomas W. Goodwin, Augusta, Speaker of House of Delegates; and J. W. Chambers, LaGrange, Chairman of Council. It was also approved that the expenses of these representatives be defrayed.

Chairman Chambers called for unfinished business and there being no unfinished business, he called for new business. On motion (Yeomans-Allen) it was recom-

mended that interns and residents be sent the *Journal of the Medical Association of Georgia* at a reduced rate or free and that this be referred to the Publications Committee for study. The motion was approved.

By unanimous vote of Council it was requested that Dr. and Mrs. H. Dawson Allen and Dr. and Mrs. Harry L. Cheves be thanked profusely for their gracious hospitality in connection with this meeting of Council. The Executive Secretary was instructed to communicate these sentiments.

Chairman Chambers then thanked the Council at large for the 100 per cent representation and the high level of deliberation carried on at this meeting.

George R. Dillinger invited the Council to Thomasville for its December meeting, and it was further stated that his invitation was gratefully received and would be referred to the Executive Committee.

The Executive Committee of Council set their next meeting for October 4 in Atlanta at the home of Hal M. Davison, MAG President-elect.

There being no further business, Chairman Chambers adjourned the meeting at 12:30 p.m.

Maternal and Infant Welfare Committee Meeting

August 21, 1955, College Park, Ga.

PETER HYDRICK, Chairman of the Maternal and Infant Welfare Committee, called the meeting to order at 11:30 a.m., Sunday, August 21, 1955 at his residence, 1233 Young Drive, College Park.

Members of the committee attending were Eugene L. Griffin and Helen W. Bellhouse; also in attendance was Mr. Milton D. Krueger, MAG Executive Secretary.

Members not present were Fred Simonton, Chickamauga; C. M. Mulherin, Augusta; George Alexander, Forsyth; Hugh Bickerstaff, Columbus; and James Bennett, Augusta. Thomas C. McPherson was excused. William L. Caton of Emory University, who was invited to attend the meeting, did not attend.

Chairman Hydrick called for a statistical evaluation of the 66 cases reported out of 134 maternal deaths in Georgia. The information concerning the cause of death with the comments of committee members were then evaluated as to whether the death was preventable or non-preventable. This review was then given to Dr. Hydrick to incorporate in an article to be submitted to the *Journal of the Medical Association of Georgia*.

The next order of business concerned the attendance of a committee member at the Tri-State Seminar to be held at Daytona Beach, September 12, 13, and 14. It was the expressed view of the committee that the committee encourage any of its members to go to the meeting, but that expenses for this meeting would not be borne by the committee.

A general discussion ensued concerning the possibility of obtaining a physician to travel and disseminate information on obstetrics around the state. It was decided that the committee request that a meeting be called within the next two weeks of a representative from the Maternal and Infant Welfare Committee of the Medical Association of Georgia; the Georgia State Obstetrical and Gynecological Society; Emory University Hospital; Medical College of Georgia; State Department of Health; and the Secretary of the Medical As-

sociation of Georgia. This meeting would also be to discuss the Midwife and Nurse Education Program concerning obstetrical work.

The committee then decided that it was ready at the present time to start on the fetal death survey and steps would be taken to initiate this program.

It was also recommended by the committee that an

autopsy report be requested when not received with the questionnaire for maternal deaths. There being no further old business, the chairman then called for new business; it was moved and duly approved that a letter of appreciation be sent to Dr. and Mrs. Hydrick for their cordial hospitality on the occasion of this meeting. The meeting was adjourned at 5:15 p.m.

The Sears-Roebuck Foundation Can Help You

THE SEARS-ROEBUCK FOUNDATION, in cooperation with the American Medical Association, has announced a new plan for assistance in establishing medical practice units with loans of up to \$25,000, beginning in 1955. The unsecured, low-cost, 10-year loans will be available to physicians seeking to establish new practices but unable to arrange full local financing.

The plan requires that the physician first exhaust all local possibilities for financing, that his application indicate a need for a practice in the proposed locality and good possibilities for success and public service, and that he give evidence of effort and thought in planning a well-organized, effective practice unit. Contributions made by the grantee in repaying the grant will be turned back into the fund for the establishment of further units, thus providing what the foundation calls "built-in chain reaction." The plan also features advantages encouraging early repayment of grants to speed up establishment of more units.

The foundation states that its plan is intended to "realize the principles of opportunity, incentive, mutual help, and self reliance; to give the American people the best possible medical care, and to help the American physician build for himself the most effective, the most rewarding and the most satisfying life as a professional man." Continuation of the plan after 1955 depends on its reception and support by the medical profession. The plan relies on individual initiative and enterprise, requires that assistance be given only where it will generate independence, and is sustained entirely by those who benefit from it.

Besides making unsecured 10-year loans to physicians seeking to establish practices, the Sears-Roebuck Foundation, after consultation with the American Medical Association, has prepared a brochure as a *Planning Guide for Establishing Medical Practice Units*.

This brochure may be borrowed from the office of the Medical Association of Georgia, upon receipt of a written request. It was financed by a grant from the Sears-Roebuck Foundation and developed with the guidance and advice of a medical advisory board appointed by the American Medical Association.

The booklet provides graphically and descriptively a

check list for doctors who wish to establish a medical practice unit in a new building—in an existing building to be remodeled—or in a building or office space to be rented.

It provides information for physicians setting up practices, expanding practices, or combining with other physicians to develop single medical units. Community leaders who are planning medical units in order to attract physicians to their towns will also find the brochure of interest and assistance. The comparative advantages and disadvantages of building, remodeling, or renting are discussed, and all the factors involved in planning a medical unit are considered for the various specialties as well as for the general practitioner.

The eight basic elements in the planning of any unit are described:

1. The reception room
2. The receptionist-control-station business office
3. The consultation room
4. The examining and treatment room
5. The laboratory (including electrocardiographic and basal metabolism apparatus)
6. The x-ray and diagnostic room
7. The lavatory
8. The utilities and storage room

Drawings and explanations of each element, along with examples of how these various elements can be combined and expanded, are presented.

Specific aspects, involving heating, ventilating, air conditioning, plumbing, and wiring are also discussed.

Actual management of practice, once the medical unit has been established, is considered in another section. Types of organization, division of income, retirement, sick benefits, death benefits, and settlement of estates are some of the subjects covered.

If you wish to borrow a copy of this pamphlet, address a request to the headquarters office at 875 West Peachtree St., N.E., Atlanta 9, Ga.

ANNOUNCEMENTS

Institute of Industrial Health of the Univ. of Cincinnati Postgraduate Course on "Modern Considerations and Methods in Handling the Lead Problems in Industry"—Kettering Laboratory, Cincinnati, November 7-11, 1955. General discussion and round table discussions will be offered. Physicians and industrial hygienists who are concerned with the lead problem and are interested in attending the course should write to the Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

Official Tour to Nassau—For members of the American Medical Association has been arranged for December 2-10, immediately following the AMA Clinical Session in Boston. By invitation from the Bahamas Medical Association a special medical meeting will be held at the Jungle Club in Nassau on Wednesday, December 7 for which a certificate of attendance will be issued. Official tour folders, containing full information, may be secured by writing to AMA *Nassau Tour Headquarters* at 35 East Monroe Street, Chicago 3.

Sectional Meetings of the American College of Surgeons—Six sectional meetings to be held in cities throughout the U. S. and Canada during 1956 are as follows: Jacksonville, Fla., January 16-18; Philadelphia, Pa., Feb. 13-16; Milwaukee, Wis., Feb. 27-29; Colorado Springs, Colo., Mar. 5-7; Little Rock, Ark., Mar. 12-13; and Edmonton, Alta., April 23-25. Panels, symposia, papers, and medical motion pictures of greatest value to doctors practicing in the area are presented. For information write to Dr. H. Prather Saunders, Associate Director, American College of Surgeons, 40 East Erie St., Chicago 11, Ill.

Caleb Fiske Prize—Subject of this year's dissertation for the essay competition is "Use of Radio-active Isotopes in the Treatment and Investigation of Disease." Dissertation must be typewritten, double spaced, and should not exceed 10,000 words. Cash prize of \$350 is offered. For information write to the Secretary, Caleb Fiske Fund, Providence 3, R. I.

Gulf Coast Clinical Society 5th Annual Meeting—Pensacola, October 27 and 28, 1955. Meeting is approved by the American Academy of General Practice for formal training requirements. Appearing on program are the following: John C. Krantz, Jr., Univ. of Maryland Medical School; W. K. Keller, Univ. of Louisville School of Medicine; Max Michael, Jr., New York State Univ.; J. E. Miller, Baylor Univ. Hospital; Grant E. Ward, Johns Hopkins Hospital; Edwin R. Levine, American College of Chest Physicians; Lester R. Dargstedt, University of Chicago; and W. A. D. Anderson, University of Miami School of Medicine. For further information address the Gulf Coast Clinical Society, 1750 N. Palafox St., Pensacola, Fla.

Medical Assembly of the Interstate Postgraduate Medical Association of North America—Milwaukee, Wis., November 14-17, 1955. Those desiring a complete program can secure it by writing Mr. Roy T. Ragatz, Executive Director, 207 Gay Building, Madison 3, Wis.

Mediclinics of Minnesota Eight Day Course—Fort Lauderdale, Fla., March 5-14, 1956. Course will consist of 32 hours of instruction made up of lectures and panel discussions on subjects having an everyday application in the general practice of medicine. It is approved by the A. A. G. P. for credit for postgraduate study. Advance reservations must be filed by November 15, 1955. Tuition fee will be \$50.00 payable in advance. For reservations address Mediclinics of Minnesota, 516 Medical Arts Bldg., Minneapolis 2, Minn.

DEATHS

WALLACE H. CLARK, LaGrange, died August 30, 1955, at the age of 66. Dr. Clark had been ill for several months.

Dr. Clark, a lifelong resident of LaGrange, graduated from the Tulane School of Medicine in 1912 and began practicing medicine the same year. He served with the U. S. Army in World War I.

He was a member of the Troup County Medical Society and a fellow of the American College of Surgeons. Dr. Clark was also a charter member of the LaGrange Rotary Club. He was a life long member of the First Baptist Church and a member of the Board of Deacons for 35 years.

Surviving Dr. Clark are his wife; a daughter, Mrs. Georgia Hendricks of LaGrange; two sons, Wallace H. Clark, Jr., New Orleans, and Mr. John S. Clark of LaGrange.

Funeral services were held in the Ida Cason Callaway Chapel of the First Baptist Church on August 31, 1955; burial was in Shadowlawn Cemetery. Pallbearers were J. S. Holder, J. W. Chambers, W. B. Fackler, C. Mark Whitehead, W. M. Hendricks, H. W. Grady, and Richard Felder.

ALFRED TENNYSON COLEMAN, Dublin, died on September 2, 1955, at the age of 71.

A native of Laurens County, Dr. Coleman was graduated from Emory University School of Medicine and did postgraduate work in New York City. He practiced medicine for 45 years after returning to Dublin in 1918. He owned and operated Coleman's Hospital there for more than 20 years. Dr. Coleman was county physician at the time of his death.

A steward and trustee of the First Methodist Church of Dublin, he was a Mason, a Shriner, and a member and past president of the Laurens County Medical Society.

Dr. Coleman is survived by his wife, the former Miss Blanche Davis; two daughters, Mrs. Albert Geeslin and Miss Blanche Coleman, both of Dublin; two sons, Mr. H. G. Coleman, Jr., and Fred J. Coleman, Dublin; two brothers, Reese C. Coleman and Mr. Jim Coleman, Atlanta.

Funeral services were conducted on September 4, 1955, at the First Methodist Church, Dublin, with burial in Northview Cemetery. Members of the Laurens County Medical Society served as honorary pallbearers.

ROBERT B. GILBERT, SR., Greenville, died August 16, 1955, in an Atlanta hospital 10 days after the amputation of both legs. He was 73 years of age at the time

of his death.

A native of Perry, Georgia, he had practiced in Meriwether County since 1906. Not long ago he estimated that he had worn out 60 automobiles and delivered more than 4,000 babies in 49 years of work as a doctor.

Dr. Gilbert was a personal friend of the late President Franklin D. Roosevelt and was credited with founding the first "Roosevelt for President Club." Under the late Governor Eugene Talmadge he served on the board which governed state hospitals and health institutions. He was also active in civic affairs of Greenville and a member of the Board of Stewards of the Greenville Methodist Church.

Survivors include three sons, the Messrs. Irvin, Robert, Jr., and Wade Gilbert, all of Greenville; a daughter, Mrs. John Hines, of Hogansville; and six grandchildren.

Funeral services for Dr. Gilbert were at the graveside in Greenville Cemetery on August 19, 1955. Mark Whitehead and James Holder, LaGrange, were among the pallbearers.

JOHN WALTON MCELROY, Ocilla, retired physician and farmer, died on August 6, 1955, at the age of 64. Funeral services were held on August 7, 1955, at the Central Methodist Church in Fitzgerald. Burial was in Evergreen Cemetery.

Dr. McElroy was born on July 30, 1891, in Macon. He served in the medical corps overseas in World War I and returned to practice medicine in Irwin, Ben Hill, and Turner counties. Dr. McElroy retired several years ago because of ill health.

He is survived by his wife, the former Miss Thelma Dorminy; two daughters, Mrs. Milton Hopkins, Jr., Fitzgerald, and Mrs. Thomas E. White, Moultrie; a brother, Mr. Andrew McElroy, Fitzgerald; a sister, Mrs. S. E. Pate, Ashburn, and five grandchildren.

SOCIETIES

The SECOND DISTRICT MEDICAL SOCIETY held its fall meeting on October 6, 1955, at the Woman's Club Building in Cairo. Officers of the society are Mervin B. Wine, Thomasville, president; H. B. Baxley, Donaldsonville, vice-president; and Julian B. Neel, Thomasville, secretary-treasurer. Those presenting scientific papers were as follows: Frank Eldridge, Valdosta—"Series of Diagnostic Studies on Scurvy"; Howard L. Cheshire, Thomasville—"Missed Abortions"; and Thomas D. Johnson, Albany—"Pulmonary Insufficiency and Oxygen Poisoning". Following the business and scientific sessions, a social hour and dinner were held at the American Legion Home.

The NINTH DISTRICT MEDICAL SOCIETY held its fall meeting in Gainesville on Wednesday, September 21, 1955, at the Gainesville Elks' Club. W. Raleigh Garner, Gainesville, president-elect of the society, gave the address of welcome. The scientific program followed the business meeting. The scientific program consisted of the following papers: "Breast Feeding," Harvey Newman, Gainesville; "Surgery of Arteriosclerosis," F. S. Durden, Gainesville; "Mitral Commissurotomy," Sam Poole, Gainesville; and "The Thyroid Nodule," P. F. Brown, Jr., Gainesville. Hall County Medical Society

members were hosts at a social hour at the Elks Club; a banquet followed. George T. Nicholson, Cornelia, has tendered his resignation as secretary and treasurer of the Ninth District Medical Society effective October 1, 1955, after having done a splendid job in this capacity for several years.

The TENTH DISTRICT MEDICAL SOCIETY met in Monroe on August 18, 1955. Hosts for the meeting were the members of the Walton County Medical Society, DeWitt Briscoe, president. Those appearing on the scientific program were Fred Cooper, Jr., Emory University, who spoke on vascular surgery; James A. Green, Athens, spoke on abdominal surgery; Gilbert M. Stevenson, Augusta, related some of his experiences combating yellow fever while in Panama; and Goodloe Erwin, Athens, spoke on rheumatic fever. A barbecue dinner followed the morning session with Harry B. Nunnally in charge of the entertainment committee. The business session followed the luncheon; Ed Maxwell, Thomson, president of the society presided.

The BIBB COUNTY MEDICAL SOCIETY met on September 6, 1955, at Pinebrook Inn, Macon. Refreshments were served at 7:00 p.m. with dinner at 7:30. The scientific program was held at 8:30. J. D. Martin, associate professor of surgery at Emory University School of Medicine, was the guest speaker. His topic was "Jaundice: Mechanisms, Diagnostic Procedures, Corrective Surgery."

The FULTON COUNTY MEDICAL SOCIETY met at the Academy of Medicine on September 1, 1955, and heard an address by Mr. Donald Hastings, president of the Atlanta Chamber of Commerce. Mr. Hastings told the members that they, like all citizens of Atlanta, should accept the responsibility for helping it develop properly. The title of his talk was "Your Problems—Your Opportunities."

A meeting of the THOMAS COUNTY MEDICAL SOCIETY was held at Archbold Memorial Hospital on September 15, and with members of the BROOKS COUNTY MEDICAL SOCIETY present it was voted to merge the two groups. The name of the new organization will be "Thomas-Brooks Medical Society."

After a social hour and dinner in the staff dining room, a scientific program was presented by Robert G. Ellison and Harry B. O'Rear, both of Augusta. Mr. John F. Kiser of the MAG headquarters office talked on activities of the Association.

Kirk Shepard, Thomasville, was elected president, at the meeting, succeeding Mervin B. Wine. Warren Taylor was named vice-president and Julian Neel was re-elected secretary-treasurer.

The WARE COUNTY MEDICAL SOCIETY met on September to hear Robert Hausman, Atlanta, director of the laboratory at Grady Memorial Hospital and professor of clinical pathology at Emory University, discuss the pathological study of a patient suffering with lupus erythematosus, a metabolic skin disease. The case history was read by Arthur M. Knight, Jr., Waycross, and William Harden, Ansley Seaman, W. F. Reavis, and W. L. Pomeroy took part in the clinical discussion of the prepared protocol. Samuel Victor presided over the meeting at the Okfenokce Golf Club; Harold Muecke, C. M. Massey, and Vilda Shuman were hosts.

PERSONALS

First District

ELLISON R. COOK, III, Savannah, recently addressed a meeting of the Optimist Club at Savannah Beach. He announced that the Savannah Rehabilitation Center would be in operation sometime in October; and that it is likely that the center will be named in honor of the late CLAIR A. HENDERSON. The center is on a site adjoining the new Memorial Hospital of Chatham County.

RICHARD A. DODELIN, Savannah, has been awarded a March of Dimes fellowship by the National Foundation for Infantile Paralysis. Dr. Dodelin received his pre-medical training and his medical degree at Emory University. He worked for some time at Grady Memorial Hospital in Atlanta and in Blackshear. He is now specializing in orthopedic surgery. He is studying at Duke University, Georgia Warm Springs Foundation, and cooperating institutions.

PETER L. SCARDINO, Savannah, was a guest speaker at the recent Annual Meeting of the Kentucky State Medical Association. The meeting was held in Louisville, Ky., September 27, 28, 29, 1955. Dr. Scardino's talk was entitled, "A Case for Social Medicine."

Second District

ROBERT G. ELLIS, Doerun, has recently located in Doerun and is engaged in the general practice of medicine. A native of Americus, Dr. Ellis is a graduate of Emory University and the Medical College of Georgia. His internship was served at Baroness Erlanger Hospital, Chattanooga. Dr. Ellis is a member of The Colquitt County Medical Society and of the staff of Vereen Memorial Hospital at Moultrie.

LEWIS HATCHER, Edison, is now occupying the offices formerly occupied by J. S. BEARD in Edison. Dr. Hatcher had previously announced the opening of his office in Dawson but decided to locate in Edison instead.

CHARLES D. HOLLIS, JR., and THOMAS D. JOHNSON, Albany, announce the removal of their offices to the Doctors Center, 1009 North Monroe Street, Albany.

William J. McAnally, Jr., Thomasville, is the new medical director of Region III of the U. S. Public Health Service. A native of High Point, N. C., Dr. McAnally graduated from Duke University Medical School in 1939. He received the degree of Master of Public Health from the University of Pittsburgh in 1952 and is a certified specialist of the American Board of Preventive Medicine, Inc. Dr. McAnally is taking over the job of M. M. Van Sandt who has been reassigned.

S. G. MULLINS, formerly of Augusta, has recently joined the staff of the Donalsonville Hospital. A graduate of the Medical College of Georgia, Dr. Mullins goes to Donalsonville from the Veterans Administration Hospital in Augusta. He is a native of Thomaston, is married, and has two children.

Third District

Robert James Hooper, formerly of Macon, has returned from the U. S. Air Force and opened his office at 416 Twelfth Street in Columbus. He is a diplomate of the American Board of Ophthalmology.

Wray J. Tomlinson, Jacksonville, Fla., has accepted the appointment as pathologist of the Columbus City Hospital. He will replace A. RALPH MONACO who resigned recently. Dr. Tomlinson will have as his assistant Donald S. Frazier. Both appointments are effective December 1, 1955. Dr. Tomlinson is a Graduate of Washington College and received his M.D. degree from Temple University. He took specialized training in pathological anatomy and clinical pathology and was certified in both specialties in 1941. He is at present chief of laboratories at St. Luke Hospital, Jacksonville. Dr. Frazier is a native of Alabama and was graduated from George Washington Medical College. He received post graduate training at the University of Tennessee in Memphis and the Henry Ford Hospital in Detroit.

Fourth District

Jackson W. Landham, Jr., formerly of Orlando, Fla., has moved to Griffin to establish his practice. He is a graduate of Emory University and Emory University School of Medicine. He served three years at Jackson Memorial Hospital in Miami and worked at the VA Hospital in Atlanta. Before moving to Griffin, Dr. Landham was doing work in cardiology in Orlando.

"Dr. McKenzie Day," in honor of J. M. MCKENZIE of Thomaston, came off in fine style on September 1, 1955. The day was set aside in recognition of his 53 years of service to Thomaston as a physician and a citizen. A platform for the ceremonies was set up on the courthouse square and two bands played, one on either side of the platform. Mr. James L. Bentley, Jr., former executive secretary to Governor Herman Tamm, was master of ceremonies. Mr. Harvey Greene, originator of the "Dr. McKenzie Day" idea, introduced members of the doctor's family. Mr. Gordon R. Holstun was principal speaker, H. A. BARRON spoke on behalf of the city of Thomaston, W. J. GOWER, President of the Upson County Medical Society, presented him with a plaque on behalf of his fellow physicians in the county; and Mr. L. T. Woodall, believed to be the oldest living "Dr. McKenzie Baby," presented the doctor with a scrapbook containing between 600 and 1,000 cards and letters from "Dr. McKenzie Babies."

Fifth District

WILLIAM S. COMPTON, formerly of Atlanta, has opened his office in Doraville for the general practice of medicine. He is temporarily located at 4661 Buford Highway in the Northwoods shopping center, but will be in the professional building when it is completed. Dr. Compton attended Emory University and the University of Georgia; he received his M.D. degree from the Medical College of Georgia. He interned at Harris Hospital, Ft. Worth, Texas, and has just completed a year's residency in surgery at Crawford Long Hospital, Atlanta. Dr. Compton is a member of the Sigma Chi social fraternity and Phi Chi medical fraternity.

ROGER W. DICKSON, Atlanta, has recently been appointed senior civilian consultant in pediatrics for the Third Army.

MARION B. HINES, professor of anatomy at Emory University, has been invited to deliver a series of lectures at Cambridge University in England this fall. Dr. Hines will address Cambridge anatomy students on the structure and function of the cerebral cortex in primates. She has studied at Cambridge, University College in London, and the University of Wurzburg (Germany).

She also holds the Ph.D. degree from the University of Chicago.

John M. Howard, former head of a medical research team in Korea, has been named chairman of the department of surgery and Joseph Brown Whitehead professor of surgery in the Emory University School of Medicine. A native of Selma, Alabama, Dr. Howard received his M.D. degree from the University of Pennsylvania in 1944 and remained as intern and resident at the university hospital until 1950. At that time he joined the staff of Baylor University, Waco, Texas. He served in Korea from 1951 to 1953, and is a consultant at Walter Reed Army Medical Center.

J. WILLIS HURST, formerly of Emory University, has recently made the front page of many papers. Dr. Hurst, who is near the end of a tour of duty with the U. S. Navy as a lieutenant commander at Bethesda Naval Hospital, was the attending physician to Senator Lyndon Johnson, Senate majority leader, when he suffered a heart attack some weeks ago.

A. H. LETTON, Atlanta, attended the recent meeting of the International College of Surgeons in Philadelphia. Dr. Letton took part in a symposium on "Diseases of the Thyroid." After the meeting he spent a few days with friends in New Jersey before returning to Atlanta just in time to start work on the Community Chest drive. He has been named co-chairman of the professional division for the second consecutive year; he also headed the medical division in 1953.

JAMES MANNING, Alpharetta, has opened an office at 206 Roswell Street in Marietta for the practice of general surgery. Following his graduation from Emory University School of Medicine, Dr. Manning served three years in the U. S. Navy; he then had one year of surgical internship at Grady Hospital and a year of residency in pathology. He served four years of surgical residency in West Roxbury and Boston V.A. Hospitals.

J. D. Meador, formerly of Winnifield, La., has opened an office for the practice of general medicine in Alpharetta. Dr. Meador is a graduate of Louisiana State University and the L.S.U. medical school. He served his internship at Charity Hospital in New Orleans, La., and one year's residency at Pineville Charity Hospital (Tulane University). Dr. Meador comes to Alpharetta from the Moseley Clinic in Winnifield.

DAVID HENRY POER, Atlanta, has been named a member of the medical advisory board of the Sears-Roebuck Foundation. Function of the board is to assist the Sears-Roebuck Foundation in the development and administration of programs of interest to the medical profession. There are 16 members of the foundation's medical advisory board, appointed from various parts of the nation.

PAUL L. REITH, Atlanta, has been appointed director of orthopedic surgery at the Warm Springs Foundation. He assumed his duties on October 1. Dr. Reith succeeds EDWIN ERWIN who resigned to enter private practice.

Sixth District

WILLIAM HUNTER, Monticello, was the guest speaker at a recent meeting of the Rotary Club of Thomasville. His talk was on the importance of the practice of medi-

cine in rural areas and the means by which help is given the people in the country who cannot come to hospitals and clinics.

H. B. JONES, Gray, has been invited to join the staff of the Macon Hospital; he is the first physician living outside Bibb County to be asked to be a staff member. In addition to his office in Gray, Dr. Jones also has an office and clinic in Monticello.

FRANKLIN C. MILES, Atlanta, has begun training in neurosurgery at the Alton Ochsner Medical Foundation in New Orleans. Dr. Miles received his M.D. degree from Vanderbilt University Medical School; following internship at Vanderbilt Hospital he served with the Armed Forces. Dr. Miles came to Crawford W. Long Memorial Hospital, Atlanta, in 1947 for his surgical residency. From 1952 to 1955 he worked under the direction of EXUM WALKER, Atlanta.

RAYMOND A. MOODY, Macon, has become associated with W. LYNN HICKS and REESE C. EBERHARDT, Macon. Dr. Moody graduated from the Medical College of Georgia in 1952 and has had three years of post graduate training at the Macon Hospital, where for the past year he has been chief resident. Doctors Hicks, Eberhardt, and Moody have moved into their recently completed Medical-Dental Building.

JULE C. NEAL and WILLIAM C. SHIRLEY, Macon, announce their association for the practice of obstetrics and gynecology in the Professional Building, Macon.

J. N. STRIBLING, Eatonton, has been made a technical advisor on the health board for the Georgia Department of Civilian Defense. A former mayor of Eatonton, Dr. Stribling has been active in veterans affairs and is vitally interested in the civilian defense program.

Two new fields of service have been set up at Macon Hospital, plastic surgery and thoracic surgery. J. P. WOODHALL was named chief of thoracic surgery, and W. H. HOLDEN was named chief of plastic surgery.

Seventh District

No news received.

Eighth District

F. N. CLEMENTS, Adel, announces the removal of his offices to North Parrish Avenue, next to the Memorial Hospital, on September 1, 1955.

BINGLEY L. BURDICK, formerly of Long Island, N. Y., has opened his offices at 707 North Patterson Street, Valdosta, for the practice of general medicine and surgery. Dr. Burdick graduated from the Jefferson Medical School in Philadelphia, interned at Kings County Hospital in Brooklyn, and entered general practice in Long Island in 1935. As soon as the doctors' building is completed near the new Pineview General Hospital he will move his offices into that building.

IVEY JACOBS, Waycross, announces the association with him in the practice of medicine of WILLIAM EUGENE HARDEN, formerly of Abbeville, Ala. Dr. Harden is a native of Montezuma and a graduate of the Medical College of Georgia. He interned at Columbus City Hospital in Columbus and has practiced for two years in Abbeville. Dr. Harden was president of the Henry County (Alabama) Medical Society. He is a member of the Lions Club and the American Legion.

W. F. LINDSAY, Hahira, announces the opening of his office at Smith Hospital in Hahira for the practice of general medicine.

Ninth District

C. L. AYERS, Toccoa, was the featured speaker at a recent meeting of the Cornelia Chamber of Commerce.

J. C. DOVER, Clayton, who has doctored Rabun Countians for over 50 years, was honored on August 26th with a "Dr. Dover Birthday Party." Approximately 300 people attended the dinner party which celebrated the physician's 80th birthday. The program included a skit in which various events in the doctor's life were acted out. As a final gesture Dr. and Mrs. Dover were presented with a silver tea service.

Dr. and Mrs. C. C. BROOKS, Blue Ridge, are now "at home" in their beautiful new residence on Sugar Loaf Mountain.

RICHARD GRAVES, Winder, has opened his offices in Winder for the practice of general medicine. Dr. Graves is a native of Clarksville and received his M.D. degree from the Medical College of Georgia in 1954. He interned at St. Mary's in Athens. He and Mrs. Graves and their small son Ricky, Jr., live at 111 Alexander Street, Winder.

A. M. HENDRIX has been elected to the City Council of Canton.

THOMAS J. HICKS, SR., McCaysville, recently returned from a three week tour of the Pacific Coast and the West including the Grand Canyon, Las Vegas, and Mexico.

Dr. and Mrs. JAMES S. MASHBURN, Cumming, announce the birth of a daughter, Van, on July 16th at Mary Alice Hospital, Cumming.

Dr. and Mrs. GEORGE T. NICHOLSON, Cornelia, their children, Patty and Jimmy, and nephew, Jerry Stiles, took quite a vacation trip this summer. They first went to Jefferson City, Tenn., to see Dr. Nicholson's alma

mater, Carson-Newman College, and then to Harrogate, his childhood home. They also took in a performance of "Unto These Hills" in Cherokee, N. C. Incidentally, Dr. Nicholson had his name in many newspapers recently as a contributor to Jimmy Hatlo's "They'll Do It Every Time."

Dr. and Mrs. A. A. ROGERS, Commerce, spent their vacation in September in the mountains of North Carolina and Tennessee.

W. FAUST DURDEN, formerly of Atlanta, announces the opening of his offices in Gainesville with practice limited to surgery. He is in the same building with HARVEY NEWMAN, III, on Spring Street.

Tenth District

Seven new department heads have been named for the new Eugene Talmadge Memorial Hospital in Augusta, each is also a department chairman at the Medical College of Georgia and a full professor. The physicians and their departments are as follows: V. P. SYDENSTRICKER, medicine; JOHN CALDWELL, psychiatry; WILLIAM MORETZ, surgery; H. B. O'REAR, pediatrics; LELAND STODDARD, pathology; L. P. HOLMES, radiology; and RICHARD G. TORPIN, obstetrics. The hospital is scheduled to go into full operation about January 1, 1956.

ROBERT B. GREENBLATT, Augusta, attended the 7th Postgraduate Assembly of the Endocrine Society, Indianapolis, from September 26th to October 1st. He participated in the demonstration of laboratory procedures and the discussion of "Cushing's Syndrome and Female Infertility. On October 3rd, Dr. Greenblatt discussed "The Use and Abuse of Endocrines in General Practice" before the Tennessee Valley Medical Assembly in Chattanooga. In Chicago, on October 4th and 5th, Dr. Greenblatt conducted two three-hour seminars on pediatric gynecology and endocrinology at the meeting of the American Academy of Pediatrics.

LELAND D. STODDARD, Augusta, gave a paper before the annual scientific assembly of the Medical Society of the District of Columbia, Washington, D. C., in October.

Therapeutic Note

TO THE DOCTORS AND PHARMACISTS OF DOUGHERTY COUNTY:

Chemists and some physicians throughout the nation are now agreed that nitroglycerine loses strength rapidly after the tablets have been exposed to air. I have studied the effects of old and fresh tablets for about seven years and agree with the above findings. Tinsley Harrison first brought this to my attention and recommended that all tablets be discarded not later than two months after exposure and advocated prescriptions be written for 100 tablets in original bottles. The 1/200 or 1/150 grs. would usually suffice where the 1/100 would rarely be needed. Take 1 p.c. orally and p.r.n.

sublingually to relieve chest pain. Communications with pharmaceutical chemists confirm the findings of the clinicians.

Now Cecil and Loeb print these recommendations on page 1326 of the 9th Edition of *Textbook of Medicine*.

Comfort and even life for your patients may depend upon your Rx. Most of you are prescribing or dispensing from broken packages. No substitute drug is better.

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COVER

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The Use of Radioactive Iodine in the Treatment of Chronic Pulmonary Insufficiency

B. SHANNON GALLAHER, M.D., WILLIAM F. HAMILTON, JR., M.D.,

IRENE F. LaMOTTE, M.D., ROBERT G. ELLISON, M.D.,

LOIS ELLISON, M.D., and W. F. HAMILTON, Ph.D., Augusta, Ga.

CHRONIC PULMONARY insufficiency has long been one of the greatest problems with which the physician has had to deal. In most instances the patient is treated with various remedies and procedures, all to no avail. In the end the patient has received no permanent relief of his dyspnea and the physician can offer no real help.

Our understanding of the work done by Blumgart, et al,^{1 2 3 4 5} Jaffe, et al,^{6 7} and others left us with the impression that the use of radioactive iodine in the treatment of advanced heart disease, angina pectoris and congestive heart failure, was a procedure of great merit. If good clinical results could be achieved in cases of severe heart disease, why could we not expect similar results in patients suffering from pulmonary insufficiency? The hypometabolic state produced by radioactive iodine should be just as beneficial to the emphysematous patient as to the one with severe coronary artery disease or congestive failure.

With this in mind William F. Hamilton, Jr., and Quimby Hair, of Augusta, initiated the treatment of a series of eight badly crippled emphysematous patients with radioactive iodine. On November 11, 1952, treatment of these patients was begun. They were followed for a year or longer from purely a clinical viewpoint. Three of them showed marked improvement, three showed moderate improvement, and two showed no improvement. The results of the treatment in this series were so impressive that

a conference was held among the departments of radiology, medicine, thoracic surgery, and physiology. It was decided to enter into a long-term investigation of the physiology and clinical course of cases of crippling pulmonary insufficiency treated with I¹³¹.

This is a preliminary report of work in progress on 16 patients to date. Its emphasis will be the evaluation of the degree of clinical improvement. The physiological findings will be presented elsewhere in detail. Suffice it to say that, at this time, the physiological data were in all cases congruent with an explanation of the clinical course. Thus in some patients the radio-iodine therapy, due to iodine saturation or other unknown cause, had little or no effect upon thyroid function as indicated by the fact that no change was induced in blood cholesterol, protein bound iodine, oxygen consumption, or blood gas tensions. The clinical course of these patients was unchanged by the treatment. These cases may be regarded as "blind tests." On the other hand, a larger group of patients showed an increase in serum cholesterol, a decrease in oxygen consumption, some decreases in protein bound iodine, an increase in arterial pO₂, a decrease in arterial pCO₂, and clinical improvement that was in rough proportion to these changes. Moreover, when the clinical improvement reversed, the laboratory findings indicated that the above changes also reversed.

As a result of the study so far, we have reached the tentative conclusion that I¹³¹ treatment palliated the distress of pulmonary cripples. It produces this effect by reducing the demand for oxygen by the body and by reducing the amount of CO₂ produced which must be eliminated by the handicapped lungs.

This paper was presented in part by Dr. Gallaher at the 105th Annual Session of the Medical Association of Georgia on May 2, 1955, Augusta.

The work was made possible by grants from the Life Insurance Medical Research Fund, the U. S. Public Health Service, and the Atomic Energy Commission.

No change has occurred in the ventilatory capacity of the lungs as indicated by the fact that the tests of maximum breathing capacity, vital capacity, timed vital capacity, residual air volume, and the difference in pO_2 between the alveolar air and arterial blood showed no significant improvement following the treatment.

The study is continuing in the hope that we may learn to differentiate, on the basis of clinical and laboratory findings, the patients who are most helped by the treatment from those who should not be treated.

We hope also to gain understanding of the physiological mechanism responsible for the change in status of the patient.

Procedure

The patients were thoroughly evaluated clinically and were tested in the laboratory as to their thyroid status and pulmonary function. If the patient were considered acceptable for the treatment, he was given 15-26 mc. of I^{131} without carrier and was dismissed to his family physician. Two months later he was brought back for both clinical and physiological re-evaluation. If re-treatment were indicated, a second dose was administered. All patients returned at two month intervals for re-evaluation and re-treatment if such were thought necessary.

Clinical Evaluation

No radiation sickness, depression of bone marrow, and no toxic effects of the blood or the kidneys have been noted. No cases of hypoparathyroidism have occurred. To our knowledge there have been no episodes of hyperthyroidism following therapeutic radioactive iodine as has been observed by other investigators.

All 16 patients were pulmonary cripples and had been severely incapacitated for a period of months to years preceding this study. There were six with severe asthma, one with silicosis, two with tuberculosis, one of whom had active tuberculosis, the other arrested, one with senile emphysema, one with bullous emphysema and three patients with cor pulmonale as a result of their long-standing pulmonary vascular insufficiency. Since the best management of cor pulmonale consists of therapy aimed at the primary, underlying pulmonary deficiency, it was felt that these patients would also benefit from therapy with I^{131} .

Most of the patients had been unable to carry on gainful occupation for one to five years prior to therapy except for two or three who were able to do light work for only a few hours a day and one who was able to carry on his business as an accountant for eight hours a day at a desk. All of the patients were showing evidence of continued incapacity after having received all standard forms of therapy.

Fifteen of the patients were males, one was female. The ages ranged from 26 to 77, the average age being 49 years. The duration of dyspnea prior to treatment was one to five years and averaged three. The period of observation following I^{131} therapy was two to 12 months and averaged six months.

In some of the patients in this series the probability of achieving a worthwhile result was admittedly small, primarily because their clinical and physiological status was so poor. Most of the patients were markedly underweight and extremely weak. Many of them had such a small pulmonary reserve that the slightest exertion such as dressing, walking across the room, or even talking or eating was enough to precipitate marked respiratory difficulty. Each patient was appraised independently by several of us before a decision was reached. Exercise tolerance was measured before and after therapy by walking with the patient up one flight of stairs.

Discussion of Results

The clinical improvement observed in these patients was graded 4+ for "Excellent," 3+ for "Good," 2+ for "Fair," 1+ for "Poor," and "0" for "No results." Out of the total 16, four patients received excellent clinical improvement, four patients received good results, four received only fair results, one had a poor response, and three were not improved at all. In other words, 75 per cent of the series received either "Excellent," "Good," or "Fair" results. The remaining 25 per cent got little or no improvement.

A patient who was considered to have received excellent results following therapy was one who had been able to return to gainful occupation, who was no longer on any other medication for dyspnea, and who was able to climb a flight of stairs without difficulty. Our best example of a patient whom we consider to have improved strikingly was a 46 year old man who had not worked for five years prior to treatment but who was able to return to work as a forestry lookout. This job requires his climbing an 80 foot tower at least twice a day; it apparently gives him no difficulty at all. In addition, he has acquired a 27 year old wife whom he had known for only three weeks before he married her. Two of the three patients who were not helped at all have died in the past two weeks, and the remaining one turned out to be the one control patient who had not been treated.

It is noted that out of the four excellent responses, two were originally euthyroid, one was minimally hyperthyroid, and one was minimally hypothyroid. Of the four good results, one was euthyroid and three were minimally hypothyroid. Of the four fair results, three were euthyroid but the fair results might

be explained on the basis that one patient had severe superimposed infection, another had pure pulmonary fibrosis, namely silicosis, and the other had an episode of a questionable acute thyroiditis following his first therapeutic dose. One of the patients graded as having received only a fair result was hypothyroid, but again this patient had severe infection plus arrested tuberculosis, far advanced. The one patient receiving only a 1+ or poor response was euthyroid, but he has only been followed for two months, and it is hoped that a little more time will render him improved.

The accurate evaluation of every clinical therapeutic measure is beset by the possibility that the favorable effect may have been the result of suggestion or spontaneous improvement due to changes in the natural history of the condition. Throughout this investigation we have tried to reduce such errors to a minimum. It was noted that hypothyroidism appearing after administration of I^{131} could not be anticipated by either the patient or the observers. It was particularly impressive to have the patient report after receiving I^{131} that for the first time in months or years he felt definitely improved and then to find definite improvement on observing exercise tolerance and on pulmonary function tests. Concomitantly the laboratory reports of PBI's, serum cholesterols, and radioactive iodine uptake studies indicated the inception of hypothyroidism.

The observed relation between the metabolic status and clinical findings supports the rationale of this procedure. Thus the very severely handicapped individual who is also severely hypothyroid seems to be little benefited and should not receive this therapy. A hyperthyroid individual would *a priori* be expected to gain from the treatment even if he is severely handicapped. We have the impression that this is so, and further that the euthyroid and minimally hypothyroid can well be helped over a considerable handi-

cap. A moderately severe hypothyroid patient can hardly expect help.

Obviously, there are many problems which deserve further study before proper selection of patients can be established. Various investigators over a period of many years and numerous patients will be necessary to permit deduction of final conclusions. This procedure is therefore proposed as a means of treating chronic pulmonary insufficiency which has become refractory to standard medical measures and is submitted for further investigation by other workers in this field. At present it can be said that many months of worthwhile existence already have been added to the lives of these disabled pulmonary cripples who were refractory to all standard forms of medical therapy.

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"Relation of Physicians and Hospitals"

JUST OFF THE PRESSES is a new pamphlet on the relationship of physicians and hospitals published by the AMA's Council on Medical Service. Entitled, "Relation of Physicians and Hospitals," this 16-page booklet contains: (1) "Guides for Conduct of Physicians in Relationships with Institutions" (adopted by the House of Delegates in December, 1951), and (2) "Report of the Joint Committee on Hospital-Physician Relationships of the Boards of Trustees of the American Medical Association and the American

Hospital Association" (adopted by the House of Delegates in June, 1953).

Since the House of Delegates adopted the position that the 1953 report should be considered a supplement to the 1951 report, both statements constitute official AMA policy on this subject and are reprinted in this edition. Medical societies, hospital staffs, and individual physicians may secure copies from the Council on Medical Service of the AMA, 535 North Dearborn St., Chicago.

Fractures of the Wrist

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JOINTS OF THE UPPER extremity have two functions. The first is motion to enable the hand to reach objects. The second is stability for the hand to do its work. Trauma to the wrist must of necessity consider the entire upper extremity from a diagnostic and therapeutic standpoint. To what avail is a beautifully reduced and maintained Colles' fracture if a "frozen shoulder" or stiff finger occurs during treatment? We must constantly strive for motion which allows the hand to be brought to objects and then to allow it to do its work.

We are mainly concerned today with Colles' fractures as it is the most commonly seen fracture of the wrist. Due to its being the most common, however, we must not be contemptuous of it. Here, as elsewhere, general principles of fracture treatment hold. A good clinical appraisal of the skin, nerves, bones, joints, and tendons is important. X-ray studies (if necessary the opposite wrist should be used for comparison) to determine the degree of displacement, comminution, and possible extension of the fracture lines into the joint are needed. Once this has been determined, an early reduction should be done under local or general anaesthesia. We have been successful in using intravenous Demerol associated with one per cent procaine injected into the fracture hematoma. Whatever method of reduction is used, the following must be established:

- 1.) Length of the radius
- 2.) Volar tilt of the distal end of the radius when viewed laterally.

If the above can be carried out and maintained we should anticipate a high percentage of satisfactory results. It is because the above are not carried out that we get bad results.

The manipulation is usually done by hyperextension of the wrist and maintaining traction while the hand is brought into slight palmar flexion, ulnar deviation and pronation to lock on the distal fragment of the radius. When reduction is complete, the hand remains in a flexed and adducted position. It does not require forceful or continuous traction to maintain. Following the reduction one frequently sees a bone defect in senile osteoporotic bones due to impaction and crushing. These fractures will settle during treatment unless the position is maintained. We

use a dorsal splint applied over a single layer of sheet cotton to maintain position. (Figures 1, 2, 3, 4) This should be changed after approximately 10 days to a more snug fitting plaster. Those cases in which settling has occurred will be apparent. It is still possible to remanipulate the fragments and regain length and volar tilt of the radius. If settling has not taken place, it is possible to bring the hand into a more normal position without losing the reduction. This cast is kept on approximately four weeks. The above method has proven successful with comminuted fractures in which settling has occurred.

Damage to the soft tissue about the wrist following fracture must be considered. One has but to recall the very tight compact arrangement of nerves and tendons about the volar aspect of the wrist to realize the possible injury that occurs in a fracture of the wrist. (Figure 5)

Of practical importance to us is the median nerve. The median nerve is the eye of the hand. Without sensation, the hand becomes relatively useless. The nerve lies on the volar aspect of the wrist passing under the transverse carpal ligament. Occasionally, a traumatic neuritis occurs as the nerve is compressed between the transverse carpal ligament and the radius. This manifests itself as a numbness in pulp of the thumb and index finger. Being unable to feel without the thumb and index finger one can do little with the fingers. This may be transitory and mild or severe and persistent. Should the latter result, division of the transverse carpal ligament at the wrist gives complete and immediate relief.

Also of importance is rupture of the extensor pollicis longus tendon (which may occur as result of manipulation or later). If the diagnosis is established, repair of the tendon should be done. If so much of its substance is lost that continuity cannot be established, transfer of the palmaris longus or extensor carpi radialis longus into the long extensor of the thumb may be necessary.

Unfortunately, our problem does not end here. We must constantly have our patients strive for finger motion throughout the course of treatment. We must stress first M-P motion to 90° and secondly I-P motion so that the finger tips are brought into the palm to touch distal to the distal palmar crease. This must be done while in the cast and following its removal. We prefer a sponge coupled with warm water

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, May 1-4, 1955.



Figure 1

Note the cast has a pressure point over the distal ulna and over proximal forearm.



Figure 2

Note pressure point 1 over the radial styloid giving three point pressure and fixation.



Figure 3



Figure 4

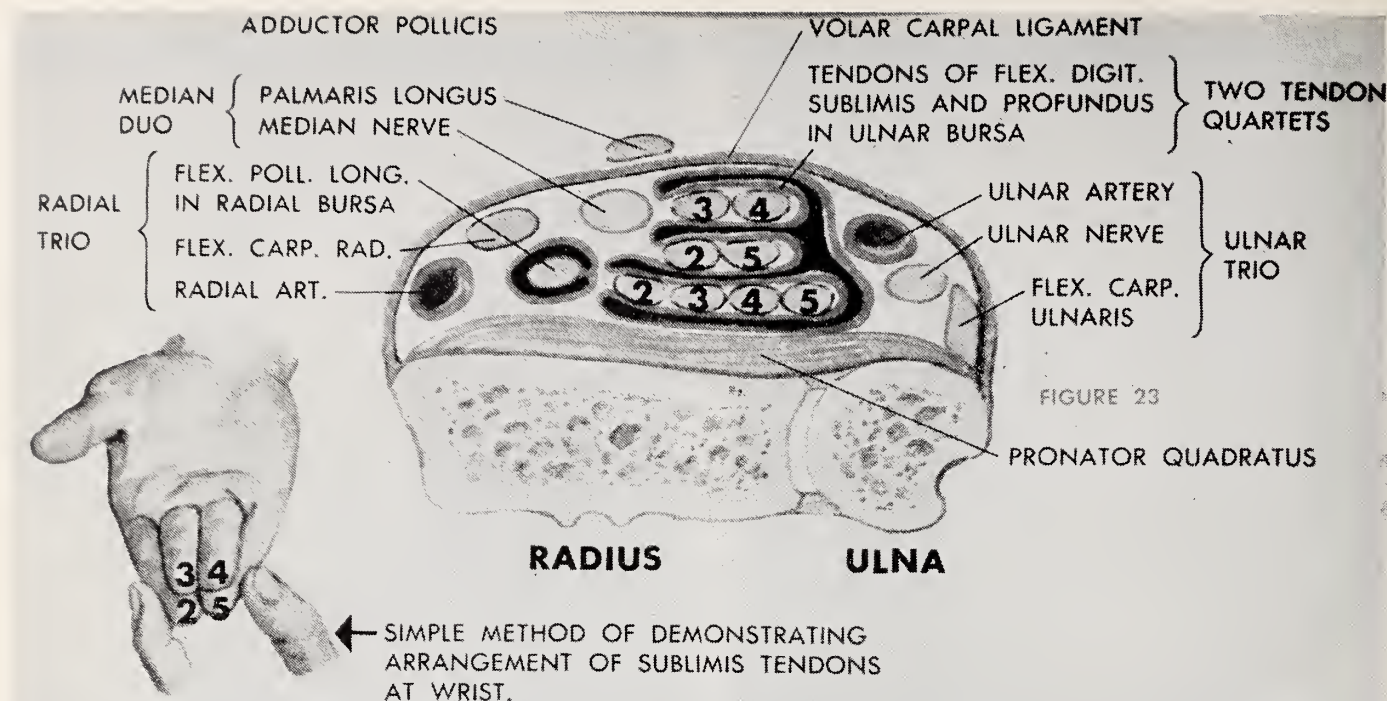


Figure 5

soaks during which the patient squeezes water from the sponge, in preference to the rubber ball. The best way to rid one's fingers of swelling is for one never to have it occur. Elevation (especially when the wrist is flexed in the cast) and constant finger motion as described are necessary. Finger joints tolerate immobilization badly. When held immobile they stiffen because their capsules tighten and synovial adhesions form.

Bacarn and Kurtzke¹ in a study of 2000 cases of Colles' fracture from the New York Workmen's Compensation Board found the average (mean) percentage loss of function (disability) was 24 per cent loss of the hand. This figure increased with the age of the patient and was in direct relation to the degree of residual deformity present. It was their opinion that physical therapy did not play any appreciable role in changing the final loss of function. In their opinion, the factors they felt to be of the greatest importance in an effort to obtain an end result with low disability were:

- 1). Accurate reduction
- 2). Adequate immobilization
- 3). Early and persistent active motion.

Summary

In summary, we must consider Colles' fracture seriously and strive to restore and maintain alignment. We must be ever mindful of soft tissues about the fracture and work to maintain a functioning hand

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Discussion

I was glad to see Doctor King's first objective in reduction of Colles' fracture was to restore radial length. This is most important in that any significant degree of shortening causes weakness in grasp and thumb function.

Rupture of the extensor pollicis longus tendon usually is a late complication from attenuation due to roughening or alteration of its groove around Listers tubercle in the distal radius. Transfer of the extensor indices proprius will very satisfactorily restore extension and already has a line of pull for performing this function. It is probably better than the extensor carpi radialis longus, which is too strong, or the palmaris longus, which lacks sufficient excursion. When the extensor indices proprius is used the distal end should be sutured to the slip of the extensor digitorum comminus to prevent rotation of the index finger.

When one truthfully evaluates all Colles' fractures it is noted that really very few have a completely normal wrist after this injury. Many of them do have a fairly good functional wrist; but some weakness, pain or limitation in some motion often persists. It is also amazing and disappointing to see a linear fracture through the distal radius without any displacement or in need of manipulation; and then when the cast is removed four to six weeks later shortening of the radius and deformity are present. Doctor King has suggested clinical evaluation of the wrist at the end of two weeks with re-manipulation in mind, and this I feel is a real contribution. Perfect reduction until it is healed offers the best chance of obtaining a normal wrist.

A Case of Complete Interruption of the Isthmus Aortae

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BECAUSE OF ITS extreme rarity we herewith present a report together with a review of the literature, embryology, etiology, physiology, and clinical findings in a case of complete interruption of the isthmus of the aorta.

CASE REPORT

DLJ (6-16-53), a white male infant, was admitted to City Hospital, Columbus, Georgia, on 6-25-53, nine days old, because of vomiting and rapid and labored respirations.

He was born of a Rh negative mother and father with a negative family history except that the maternal grandparents had two children die in infancy of unknown causes. The patient's mother was never sick during the entire gestation, ate well, had no x-ray of any kind and no vaginal bleeding. Labor was uneventful, and examination of the infant was perfectly normal at time of birth. He weighed eight pounds.

He did well until the day of admission when he became restless, began vomiting, and nursed the bottle poorly. About 12 hours after onset he developed a distressed cry, and his breathing became labored with a slight expiratory grunt. There were transient areas of cyanosis on the lower extremities. He suddenly developed a shock-like picture about 20 hours after onset and was hospitalized.

He was quite pale, moribund, breathing rapidly with flaring of the alae nasae. Lungs were clear to auscultation. Heart appeared enlarged and heart rate was between 190-220. No murmurs were heard at that time. Abdomen was distended and liver was down $2\frac{1}{2}$ fingers-breadths below the costal margin, and the spleen edge was palpable. His temperature was 96.6° F.

Upon admission he was surrounded by hot water bottles, given oxygen, penicillin, streptomycin, cortisone, and was digitalized. X-rays were taken which showed the heart to be markedly enlarged in all directions. There was a moderate amount of gas in the stomach. ECG showed a tendency to right axis deviation. Red blood cell count was 5.09 million, hemoglobin, 125%, 17.8 grams; white blood cell count, was 20,150, 4 stabs, 28 segs, 66 lymphs, 1 eosin. and 1 monocyte. Urinalysis was negative.

On above therapy he improved, came out of shock, temperature went up to 102° F., and his heart rate came down to 180 per minute. He continued to vomit. Femoral pulses were present, and it was not until his heart rate came down to 136 that a definite systolic murmur could be heard over the pulmonic, tricuspid, and mitral areas extending into the left axilla and also between the scapulae. About three hours after admission, fine crepitant rales were heard throughout both lung fields. Respirations became uneven, and he began having carpal spasms. Abdominal distention was so prominent a picture together with the vomiting that a surgeon was asked to see the patient, but this was not considered a surgical abdomen. The patient would not nurse and had to be hydrated by subcutaneous clyses. The following day he became progressively worse and continued having generalized clonic convulsive movements until death on 6-27-53, approximately 48 hours after admission.

Autopsy Report: Except for generalized congestion of most organs, the essential features of the examination were in the heart. The heart was $1\frac{1}{2}$ times usual size, and the lungs were compressed, pink, and subcrepitant. On opening the heart a small high interventricular septal defect was encountered. Both ventricles were dilated and their walls were thickend. The ascending aorta was in the usual position, but extended up and branched into the innominate, left common carotid and left subclavian arteries. No arch of the aorta was found. The pulmonary arteries were normal, but the descending aorta was connected at

the bifurcation by the ductus arteriosus. The liver was enlarged and weighed 120 grams. In the central half of the lobule the sinusoids were widened and filled with blood.

Review of the Literature

Complete interruption of the isthmus aortae is a rare anomaly. There have been two reviews made of the literature on this subject, one by Hamburger¹ in 1937 and another by Weisman and Kesten² in 1948, and we have reviewed the literature since that time.

Weisman and Kesten point out that evaluation of the older literature is difficult because of frequent lack of sharp differentiation between, on the one hand, complete loss of continuity along the arch and, on the other, mere narrowing or even atresia with a cord-like vestige remaining, but we have done the best we could. Abbot³ emphasized that complete disappearance of part of the aortic arch may happen in one of two sites: (a) in the descending arch between the orifice of the left subclavian artery and the entrance of the ductus arteriosus, which vessels form the descending aorta, this type being merely an extreme form of coarctation, and (b) much more rarely, in the transverse arch just after the origin of the left common carotid and before that of the left subclavian artery, which vessel is given off from the descending arch of the aorta with no connection between the latter and the transverse arch. However, interruption may occur anywhere in the arch. Edith Potter states that in her experience site "a" is more rarely seen than "b".¹⁰

Weisman and Kesten's² review was an adequate one, and they claimed there were 13 cases of type "b" interruptions on record. From studying their review, we find 15 cases of complete interruptions including their own in which the interruption occurred proximal to the left common carotid artery as well as the left subclavian, both these vessels arising from the entirely separate portion of the trunk of the pulmonary artery and the descending aorta. There were defects in the interauricular and interventricular septums. Their case was suspected of intra-abdominal disease just as our case.

Out of 15,000 autopsies reviewed at Johns Hopkins Hospital, Hamburger¹ had found one case of complete interruption of the arch of the aorta associated with transposition of the great vessels, and

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, May 1-4, 1955.

Evans⁴ had one case interrupted at the isthmus similar to our case and two cases above this level. Not mentioned by Weisman and Kesten are two cases referred to by Letterer⁵ in 1923, one of his own and one of Berblinger.

In 1929 Gaspar⁶ reported a case of absence of the aortic arch with stenosis of the arch and with defect in the interventricular septum. Interruption occurred between the left common carotid and left subclavian which came off the descending aorta.

In 1948 Margaret Stewart⁷ reported a case similar to ours in which the interruption occurred distal to the left subclavian and was associated with an interventricular septal defect. It only lived 45 hours.

In 1952 Jew and Gross⁸ reported a case of interruption of the transverse arch of the aorta associated with a right pulmonary artery arising from the ascending aorta. The interruption occurred between the left common carotid and left subclavian arteries, and interauricular and interventricular septal defects were also present.

In 1953 Edwards⁹ reported a case of Roger W. Morrison which was of the type "b" interruption. An IV septal defect was also present.

In 1954 Barger, Creasman, and Edwards¹⁰ reported an interesting case in which the interruption was associated with bilateral ductus arteriosus. The right ductus arteriosus gave rise to the right subclavian artery, and the ascending aorta terminated by dividing into the two common carotid arteries.

Therefore, to date there have been reported and referred to 22 cases of complete interruption of the arch of the aorta. There are 16 cases of Abbot's type "b" interruptions reported, and, of course, these are not all similar because the associated anomalies vary. We very carefully studied the cumulative indices since 1927 and accepted Hamburger's and Weisman and Kesten's reviews prior to this time, and we have found only one case exactly like ours and that is the one reported by Margaret Stewart⁷ in 1948. Whether the cases reported by Herxheimer¹¹ in 1910, the one case of Evans⁴ in 1933, and Letterer⁵ in 1923 were of the type "a" variety, as is our case, we cannot say. However, we believe that we are adding the 23 case of complete interruption of the arch of the aorta to the literature.

To understand the defect in question one must understand the development and fate of the aortic arches.

In earliest embryonic life the principal blood vessels consist of paired longitudinal dorsal and ventral arteries known as dorsal and ventral aortae. The two ventral aortas fuse at one point to form the heart, and the two dorsal ones fuse to become the descending aortae. Anterior to these areas of fusion a series of vessels connecting the ventral and dorsal aortae

develops on each side of the body known as the aortic arches.

The period of development of the aortic arches extends throughout the fourth week, and their transformation mainly occupies the fifth to seventh weeks. The characteristic changes of this region are brought about by the loss or interruption of some arches and segments of the aortae due to reduction or stagnation of blood flow, and by the enlargement of certain vessels and the new formation of others.¹²

The first and second pairs of aortic arches drop out early. The dorsal aortae at the level of these arches persists, but between the third and fourth arches both vessels atrophy. The outcome on each side is a continuous vessel beginning with the third arch and continued by way of the dorsal aorta to the head region. These vessels are the primitive internal carotid arteries, which not only branch in the head to supply the brain, eyes, and ears but also connect with the basilar artery. The common stem of the third aortic arch proximal to the origin of the external carotid is known as the common carotid.

Both fourth arches persist. On the left side the arch is commonly said to represent the permanent arch of the aorta. To the primitive arch, however, is added proximally the left half of the aortic sac and distally that segment of the left dorsal aorta next caudad. On the right side the right half of the aortic sac elongates into the innominate artery which then serves as the main stem for both the common carotid and subclavian vessels of that side. A patent ductus arteriosus is due to persistence of the left sixth aortic arch.

Anomalous blood vessels may be due—(1) to the choice of unusual paths in the primitive vascular plexuses, (2) to the persistence of vessels normally obliterated, (3) to the disappearance of vessels normally retained, (4) to incomplete development, and (5) to fusions and absorptions of parts usually distinct.

Congdon has shown that the aortic arches develop in regular sequence from before backward as the heart shifts caudally to occupy its final position within the thorax. Normally the division of the current of blood which supplies the head and upper extremities and that which is directed to the trunk and lower extremities occurs between the third and fourth aortic arches.

According to G. L. Streeter, the blood vessels develop in response to the stress and strain placed on the primitive vascular bed. If this is true, it is easy to understand how a slight variation in the rotation or position of the heart or in the formation of the ventricles may lead to anomalies in the development of the great vessels.

If the heart comes to rest a fraction of a millimeter farther caudally than is normal, the division of the stream of blood between the upper and lower extremities will occur between the fourth and sixth aortic arches. Under such circumstances, the descending aorta becomes continuous with the pulmonary artery through the ductus arteriosus. Indeed, when one sees how close together these two vessels lie, that is the fourth and sixth aortic arches, it is surprising how rarely the descending aorta becomes continuous with the pulmonary artery.¹³

Warkany and Wilson¹⁴ wrote that each organ has a critical period during which it is most susceptible to environmental changes. For the production of normal offspring these regressive processes, like the ones concerned with progressive developments, must begin at the appropriate time and proceed at the proper rate. Failure of these regressions to occur, or to occur at the proper time and rate, constitutes one variety of maldevelopment. With a given arch or any other structure subject to regression under ordinary circumstances, there is a temporal difference affecting its progressive development and influences affecting its regressive development. Interference with the former results in either aplasia or hypoplasia; interference with the latter results in abnormal retention. Therefore, the abnormal retention of an aortic arch indicates that the adverse influence that altered normal development reached a critical level of effectiveness at a relatively later time than did a similar influence that caused aplasia of the same arch in another animal.

Warkany's experiments were all done on animals, and he actually produced abnormalities of the arch of the aorta by depriving pregnant animals of vitamin A.¹⁵ No such deprivation in humans has produced such abnormalities as far as we know. We know of no abnormal conditions to which our patient's mother was subjected in the first six to eight weeks of pregnancy.

The essential feature of this malformation is the complete interruption of the isthmus of the aorta. The descending aorta is continuous with the pulmonary artery through the ductus arteriosus.

The blood from the right auricle flows into the right ventricle and out by the pulmonary artery to the lungs and through the ductus arteriosus to the descending aorta. The blood from the lungs is returned to the left auricle and thence to the left ventricle and is pumped out through the aorta to the head and upper extremities. The blood from the head and upper extremities is returned by the superior vena cava to the right auricle, and the blood from the trunk and lower extremities is returned by the inferior vena cava to the right auricle. Therefore, with each car-

diac cycle the right auricle receives all the blood which was pumped out from the left ventricle to the head and upper extremities and also that part of the blood from the right ventricle which was pumped from the pulmonary artery through the ductus arteriosus to the trunk and lower extremities. The left auricle receives only that part of the blood from the right ventricle which was directed through the pulmonary artery to the lungs. Therefore, the pressure in the right auricle and right ventricle is greater than the pressure in the left auricle and left ventricle, and therefore, in our case, some blood flows from the right ventricle to the left ventricle through the interventricular septal defect. The pressure in the left ventricle might possibly rise and give a reversal of shunt, but the pressure usually tends to remain higher in the right side of the heart as more blood is always returned to the right auricle than to the left auricle, eventually causing right heart failure.

The most important diagnostic clue is the difference in cyanosis between the upper and the lower extremities. The upper extremities receive oxygenated blood from the left side of the heart, whereas the lower extremities receive venous blood from the descending aorta. The presence of the septal defect probably allowed enough admixture of blood that there was no sharp line of demarcation in our case. When it is present the line of demarcation of the cyanosis lies at the brim of the pelvis. It is always best appreciated by placing the patient's hand beside the foot. If cyanosis is noted in the lower extremities it is liable to be attributed to cold or to a sluggish circulation. If the feet remain cyanotic when warm then this offers the clue to the correct diagnosis.

The pulse is of good quality and of equal strength in the arm and the leg in contrast to coarctation of the aorta. The heart is slightly to moderately enlarged, predominantly the right side. Murmurs may or may not be present. ECG shows right axis deviation.

It is interesting that our case and also that of Weisman and Kesten presented themselves with vomiting and abdominal distention pointing to the abdomen as the probable site of pathology.

Taussig¹³ states that the prognosis is usually determined by the associated anomaly rather than by the condition per se, but we feel quite certain that our case died of congestive heart failure secondary to overloading of the right ventricle and not the IV septal defect.

Summary

A case of complete interruption of the isthmus of the aorta has been presented which we consider probably the twenty-third case reported. There was an associated interventricular septal defect, and the in-

fant lived nine days. The embryology, etiology, physiology, and clinical picture were discussed.

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Hospital Beds Needed in Georgia

HOSPITAL CONSTRUCTION in Georgia was delayed about 15 years because of the shortage of money during depression years and the scarcity of building materials during the World War II period. In the meantime the State's population continued to grow. There was an encouraging rise in the economic level and with it an increased awareness of health needs. Prepaid hospitalization plans were inaugurated. All this resulted in an acute shortage of all types of hospital facilities and services.

Congress passed a hospital survey and construction act in 1946, known as the Hill-Burton Act, which authorized money on a matching basis for helping communities with part of the cost of building public or other non-profit hospitals and related health facilities. At that time there were only about half enough general hospital beds available in Georgia.

In the past eight years a total of 6,667 new general hospital beds have been made available in hospitals completed or placed under construction. Of these 3,730 were authorized under the Hill-Burton program and 2,940 were financed in other ways. Now 72 per cent of the need for general hospital beds has been provided.

According to Georgia's 1955 state hospital plan, which is required under the Hill-Burton law, there were 241 hospitals and clinics in Georgia. Of these facilities 134 were classified under federal standards as "Acceptable," and 107 as "Replaceable Structures," from the standpoint of hospital planning and public safety.

Approximately 500 new hospital beds are required each year in Georgia merely to replace obsolete facilities and to provide for the normal population in-

crease, without taking into account beds needed to decrease the general hospital bed deficit.

In addition to the 72 per cent unmet need for general illness, there is need for an expansion in the variety of services offered by hospitals. Diagnostic and treatment facilities for ambulatory patients are needed. These should include clinical laboratory and diagnostic x-ray services.

Rehabilitation services are needed which, if started early and properly applied, can shorten hospital stay. Such care also permits the sick person to make an early return to normal living and productivity.

In some respects, the problem of adequate facilities for long-term patient care is probably the most acute medical care problem. Although many chronically ill patients are receiving some type of care in the state, it is too frequently provided either by expensive general hospitals for short-term acute illnesses or in nursing homes that are neither safe nor satisfactory.

In order to encourage communities to meet the need in the chronic disease category and to provide related medical facilities such as diagnostic and treatment centers, nursing homes, and rehabilitation facilities, the hospital law was amended in 1954, for this purpose.

During the spring of 1955, a special inventory was made by the Georgia Department of Public Health of facilities and services in each of the categories. According to this survey the current need for each category was:

- 7,112 additional beds in chronic disease hospitals.
- 10,683 beds in nursing homes.
- 356 diagnostic-treatment centers.
- 12 rehabilitation centers.

Disability Evaluation

EARL D. McBRIDE, M.D., Oklahoma City, Okla.

THE EVALUATION of disability is an appraisal of the extent of the functional state of an individual which has depreciated from normal. It may be rated as a percentage loss, or it may be itemized in specific definitions of disabling factors. If a person is partially and not totally disabled, he should be given credit for what he still can do, as well as having pointed out that which he cannot do, in light of the per cent loss for the disability. That is, now that he has been injured and is still partially disabled, can he do his regular work? Must he re-establish himself at a job selected according to his remaining ability to work? Under these circumstances, what is his per cent of disability?

This process should not be so difficult if external influences are not permitted to create confusion or unscientific reactions. Usually there is a claim involved, either for industrial injury compensation or for damages. Conflicting contentions, court hearings, and attempts to resist losses or to attain monetary gain often tend to create frank frustrations that mask the true medical facts. Furthermore, the inability to clearly define the influence or responsibility, of current or pre-existing disease, versus the true disabling results of injury often creates indecision and misconception. Actually the evaluation of disability should be confined strictly to the process of achieving a comprehensive inventory based on the history, the physical examination, the laboratory procedures, and the assessment of the functional limitations created by the physical disability which is found.

Various Stages of Disability

Various stages in the recovery of an industrial injury may be classified as:

1. The period of temporary disability
 - (a) Active treatment
 - (b) Rehabilitation
 - (c) Maximum improvement
2. The state of permanent disability
 - (a) Partial permanent
 - (b) Total permanent

Usually the period of temporary total disability is considered to exist so long as the disability prevents the person from returning to work at any gainful occupation. When active treatment is ended, limited

opportunity for rehabilitation may still be an obstacle to the resumption of work. The industrial employee is often dismissed by his doctor only to find that he still has weakness, instability, stiffness, and other residuals of the injury which will not permit him to do his regular job with the efficiency expected of him. If advised by his doctor that he can start in at light work he may find that his employer has no light work. Before maximum improvement can take place he must either rehabilitate himself or rehabilitation must be provided through special arrangements. Many times the rehabilitation enigma results in a settlement obstruction with precarious consequences. Psychoneurosis, exaggeration, adverse incentive to work, and many other factors become superimposed to mask the actual extent of the physical depreciation from normal.

Permanent Disability

Permanent disability may be defined as a permanent and irreversible state of body impairment which limits the normal capacity of the individual to perform useful work. Permanent disability may be total or partial. Permanent total disability implies an impairment of mind or body which is sufficient to render it impossible to follow a gainful occupation throughout life. Usually the compensation laws consider amputation of both arms, both legs, or loss of both eyes as a total permanent disability. Permanent partial disability implies the ability to follow a gainful occupation to a limited degree. These same terms are also applied to the extremities. In industrial injuries permanent total loss of an extremity is usually provided for by specific awards, based on the level of the amputation. Consequently, a disability which is less than that of an amputation must be designated as a partial disability. Since partial disability is not usually defined or specified by the statutes, such responsibility rests on medical opinion.

There are two extremes that may arise in making examinations and reports on cases with disability claims:

1. Where the subjective complaints are obviously exaggerated.
2. Where the results of injury are found to be anatomically severe, but little or no complaint of symptoms is made because the patient stoically minimizes his complaints through his ambitions to return to his wage earning job.

Presented at the 105th Annual Session of the Medical Association of Georgia, May 1-5, 1955, in Augusta.

The exaggerator should not be over-rated for his actual disability, and the complacent, easily satisfied person should not be penalized for his willingness to cooperate.

Exaggeration is a form of self pity, and is quite a natural defensive reaction in the individual who feels that he has been damaged through the fault of others. One who is accustomed to examining claimants finds it difficult to reconcile the inconsistencies between over-emphasized subjective complaints and the minimum of actual physical findings to support them.

Patients with disturbances of the neuro-muscular and emotional equilibrium often recover abruptly with final settlement of the case. On the contrary, when the individual with severe anatomical damage to his body greatly suppresses his complaints, the extent of disability may be unequitable.

CASE REPORT I

J. T., aged 32, an oil field roustabout, had a severe comminuted intra-condylar fracture of the left femur, with a compound fracture of the left os calcis, together with injuries to the cuboid and the metatarsals of his foot. A considerable portion of the os calcis was removed to eliminate a sequestrum of osteomyelitis. He begged to return to his regular job before his injuries were completely healed. He was permitted to do so at his regular wages. Many individuals with residual anatomical alterations as severe as his would have been off work much longer and would have held out for a settlement of his permanent disability, rather than return to work.

As a result, due to his ambitions, he mobilized his stiffened knee quite rapidly and from external appearance seemed to have very little loss of function. Should he not be awarded adequately for his physical damage? Even though he returned to his regular job and had comparatively little loss of function?

CASE REPORT II

An opposite type of case was M. R., aged 42, coal miner, who claimed he wrenched his back while unloading a car. A severe stabbing pain struck him in the left iliolumbar region, but he continued at work until quitting time, one hour later. He had only been employed at this particular job six weeks, and he was hired during a period of labor trouble. On examination six months following the injury he jerked away, even on palpation, and complained of pain in almost any area of his low back. He had numbness over his entire left leg and limped severely. There was no definite involuntary muscle spasm, and none of the conventional tests for sciatica, iliolumbar, or sacroiliac injury were adequately positive. His neurologic tests and all other clinical examinations failed to show evidence of definite pathology. The x-ray films showed a transient fifth lumbar vertebra, unilateral, on the right. Opinion on his disability varied widely. How can the true measure of this man's condition and disability be judged fairly? If he can be given credit for his claim of actual, acute, catch-like pain and strain to his back and the possibility that the anomaly of the fifth lumbar may have been an influencing susceptibility to injury, how should his mental reactions be dealt with since they are definitely preventing him from returning to work? It is quite certain a settlement will cure him, but what is his per cent of permanent disability if a settlement is to be awarded in court?

Necessity of Systematic Procedure in Evaluating Disability

Are we to be arbitrary or scientifically sound in judging the extent of disability? Since physical disability may result from many factors involving the effects of injury, it is necessary to use some specially devised method of systematically investigating, analyzing,

and establishing a dependable diagnosis of the situation at hand. Only then can a reasonable rating of disability be established. The medical profession has never established an acceptable method for such purposes, yet its members are called upon daily to assume such responsibilities. Many physicians frankly admit they do not know how they arrive at a conclusion as to the per cent of disability. No doubt in many instances the doctor reflects his own sensibilities as to what he would expect if he were in the position of the claimant. In other instances he may be overwhelmed with what he finds, or does not find, in the x-ray films. Others may be unduly impressed with the subjective complaints, or the misfortune of the individual. Some physicians are naturally conservative and belittle unsubstantiated complaints. Others are liberal and give the claimant all benefit of doubtful findings. Unfortunately there are some who lend themselves too freely to the suggestions and desires of one or the other of the contending parties.

Why should these variations in attitude toward disability claims exist? Should not the subject of disability evaluation be treated strictly as a scientific subject and give it the same professional dignity as any other medical activity? If so, then some method of formulating an opinion as to the per cent of disability should be systematically followed on just as purely an analytical basis as that of making a diagnosis in a medical or surgical case.

The author has published many suggestions regarding this subject. The following is a brief abstract of a method of analysis. First of all, the method must include a measuring rule that will reconcile the losses resulting directly or indirectly from the injury with the remaining normal functions that may be adjusted to some gainful occupation. The maximum assessment for disability is the amount specified by law for total permanent disability. Permanent partial disability is a per cent of the total, but in only a few instances are permanent disabilities included in the schedule provided by law. All of the disabling factors must be elicited and weighed in the mind of the examiner in order to arrive at an evaluation of the disability loss, as compared to the normal state still available to the individual.

A Formula to Establish Per Cent Loss

The author has devised an analytic formula to weigh the losses leading to disability.* It requires a certain extent of mathematical concentration which is not as agreeable to most doctors as the conventional methods of making medical diagnosis; nevertheless, some such effort must be adopted for disability evaluation. This formula may be applied to the body as a whole or to any particular part as required. For the body as a whole, total permanent disability should be 100 per cent. For a finger, leg,

**Disability Evaluation*—Earl D. McBride, M.D., 5th Edition—published by J. B. Lippincott Co., Philadelphia, Pa.

International College of Surgeons, October 1954.

Academy of Orthopedic Surgeons Instructional Courses, January 1955.

MEDICAL ANALYSIS OF PERMANENT PARTIAL DISABILITY

Date _____

PATIENT'S NAME _____ ADDRESS _____

CHECK PART OR PARTS OF BODY DISABLED:

Whole Body | Fingers (1-2-3-4) | Thumb | Hand | Arm | Leg | Foot | Toe |

DUE TO PRE-EXISTING
DUE TO INJURY INJURY OR DISEASE

THE PARTIAL TEMPORARY DISABILITY IN THIS CASE IS: _____ Per Cent _____ Per Cent _____ Per Cent

THE PERMANENT PARTIAL DISABILITY IN THIS CASE IS: _____ Per Cent _____ Per Cent _____ Per Cent

PRESENT STATUS OF INDIVIDUAL

Maximum improvement reached?

Yes No

Condition Stationary?

Yes No

Further Treatment indicated?

Yes No

Rehabilitation indicated?

Yes No

This percent of disability is based on thorough physical examination in which the following unit factors of disability have been fully analyzed and averaged. Uninvolved factors remain to the normal advantage of the individual.

DISABILITY DIRECTED TOWARD

1. ORDINARY MANUAL LABOR

Yes No

2. SPECIFIED OCCUPATION

Yes No

TWO PROPORTIONAL COMPONENTS OF DISABILITY

1. FUNCTIONAL DEFICIENCY Rating 75 Percent
7 Units 100 Percent each
2. PHYSICAL DISORDERS Rating 25 Percent
5 Units 100 Percent each

Total Rating 100 Percent

FORMULA FOR RATING DISABILITY:

Insert total percentages of unit losses

Functional Deficiency _____ %
700 X .75 + 500 _____ % X .25 = _____ % Disability
Physical Disorders

THE PERCENTAGE RULE OF SEVERITY

Apply this rule to each factor of all the units to estimate percent of severity.



Apply rule of severity to evaluate each factor loss
FUNCTIONAL DEFICIENCY UNIT VALUE % 700 PERCENT.

Normal value each factor 100%
Compute Loss each Factor

1. QUICKNESS OF ACTION
2. COORDINATION, SKILL
3. STRENGTH
4. SECURITY, CONFIDENCE
5. ENDURANCE
6. SAFETY, UNDUE RISK
7. PRESTIGE OF PHYSIQUE

For employment

Grand total Component Functional Deficiency _____ Percent

PHYSICAL DISORDERS UNIT

TOTAL VALUE 500 PERCENT

Evaluate percent loss each unit deviates from 100% normal. Total loss for each entire unit cannot be over 100 percent. Transfer grand total percentage loss to the formula on the opposite page to obtain percent of disability. Write in unlisted items. If pathology is pre-existing, so designate.

Apply rule of severity to evaluate percent loss of each unit

ANATOMICAL MASS DAMAGE UNIT

(Objective findings only)

Percent less than normal in this case _____%

Check involved factors

- | | |
|---|--|
| <input type="checkbox"/> 1. BONE DEFORMITY | <input type="checkbox"/> 9. BRAIN, CORD, NERVES |
| <input type="checkbox"/> Excess callous | <input type="checkbox"/> Hemorrhage |
| <input type="checkbox"/> Shortening | <input type="checkbox"/> Maceration |
| <input type="checkbox"/> Mal-union | <input type="checkbox"/> Meninges |
| <input type="checkbox"/> Non-union | <input type="checkbox"/> Myelitis |
| <input type="checkbox"/> Angulation | <input type="checkbox"/> Compression |
| <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Severance |
| <input type="checkbox"/> 2. SPINE DEFORMITIES | <input type="checkbox"/> Neuroma |
| <input type="checkbox"/> Herniated disk | <input type="checkbox"/> Degeneration |
| <input type="checkbox"/> Joint asymmetry | <input type="checkbox"/> 10. BLOOD VESSELS |
| <input type="checkbox"/> Anomalies | <input type="checkbox"/> Severance |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Varicosity, Phlebitis |
| <input type="checkbox"/> Fracture, Deformities | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Disease: Arthritis | <input type="checkbox"/> Thrombus, Embolus |
| <input type="checkbox"/> 3. JOINT PATHOLOGY | <input type="checkbox"/> Arteriosclerosis |
| <input type="checkbox"/> Altered axis | <input type="checkbox"/> 11. BURSA, SYNOVIA |
| <input type="checkbox"/> Articular destruction | <input type="checkbox"/> Disease |
| <input type="checkbox"/> Ligamentous changes | <input type="checkbox"/> Adhesions |
| <input type="checkbox"/> Disease: Arthritis | <input type="checkbox"/> 12. VITAL ORGANS |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Contusion |
| <input type="checkbox"/> 4. MUSCLE DEFICIENCIES | <input type="checkbox"/> Lacerations |
| <input type="checkbox"/> Altered mechanics | <input type="checkbox"/> Disease |
| <input type="checkbox"/> Rupture | <input type="checkbox"/> 13. SYSTEMIC DISEASE |
| <input type="checkbox"/> Contractures | <input type="checkbox"/> Concurrent or preexisting |
| <input type="checkbox"/> 5. EYE INJURY | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Puncture | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Enucleation | <input type="checkbox"/> Other disease |
| <input type="checkbox"/> Scar | <input type="checkbox"/> 14. SKIN, FASCIA |
| <input type="checkbox"/> 6. EAR INJURY | <input type="checkbox"/> Loss of tissue |
| <input type="checkbox"/> Drum | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Ossicles | <input type="checkbox"/> Contractures |
| <input type="checkbox"/> Mastoid | <input type="checkbox"/> Eruptions |
| <input type="checkbox"/> 7. SKULL | <input type="checkbox"/> Other Factors |
| <input type="checkbox"/> Scalp, face | <input type="checkbox"/> 15. GENITO-URINARY |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Ureters |
| <input type="checkbox"/> 8. CHEST | <input type="checkbox"/> Kidneys |
| <input type="checkbox"/> Ribs | <input type="checkbox"/> 16. OTHER FACTORS |
| <input type="checkbox"/> Lungs | |
| <input type="checkbox"/> Heart | |

JOBS RESTORATION UNIT

(Restrictions of Physical requirements)

Percent less than normal in this case _____%

Check involved factors

- | | |
|---|--|
| <input type="checkbox"/> 1. LIFTING | <input type="checkbox"/> 11. STOOPING |
| <input type="checkbox"/> Heavy | <input type="checkbox"/> 12. BENDING |
| <input type="checkbox"/> Light | <input type="checkbox"/> 13. CLIMBING |
| <input type="checkbox"/> 2. PULLING | <input type="checkbox"/> 14. THROWING |
| <input type="checkbox"/> 3. PUSHING | <input type="checkbox"/> 15. BALANCING |
| <input type="checkbox"/> 4. REACHING | <input type="checkbox"/> 16. VISION |
| <input type="checkbox"/> overhead | <input type="checkbox"/> Efficiency |
| <input type="checkbox"/> 5. GRIPPING | <input type="checkbox"/> Color |
| <input type="checkbox"/> Finger dexterity | <input type="checkbox"/> 17. HEARING |
| <input type="checkbox"/> Fist power | <input type="checkbox"/> 18. QUICK THINKING |
| <input type="checkbox"/> Holding | <input type="checkbox"/> 19. SPECIAL TALENTS |
| <input type="checkbox"/> 6. WALKING | <input type="checkbox"/> 20. OTHER FACTORS |
| <input type="checkbox"/> 7. RUNNING | |
| <input type="checkbox"/> 8. LONG STANDING | |
| <input type="checkbox"/> 9. CRAWLING | |
| <input type="checkbox"/> 10. KNEELING | |

RESTRICTIONS WORKING CONDITIONS UNIT

(Environmental factors no longer can be tolerated)

Percent less than normal in this case _____%

Check involved factors

- | | |
|--|--|
| <input type="checkbox"/> 1. OUTSIDE | <input type="checkbox"/> 11. WATER |
| <input type="checkbox"/> 2. INSIDE | <input type="checkbox"/> 12. SOLVENTS |
| <input type="checkbox"/> 3. HOT | <input type="checkbox"/> 13. DARKNESS |
| <input type="checkbox"/> 4. COLD | <input type="checkbox"/> 14. SLIPPERY FOOTINGS |
| <input type="checkbox"/> 5. SUDDEN CHANGE | <input type="checkbox"/> 15. MACHINERY HAZARDS |
| <input type="checkbox"/> 6. DAMPNESS | <input type="checkbox"/> 16. IRREGULAR HOURS |
| <input type="checkbox"/> 7. DUST | <input type="checkbox"/> 17. RIDING, OR |
| <input type="checkbox"/> 8. RADIANT ENERGY | <input type="checkbox"/> DRIVING STRAIN |
| <input type="checkbox"/> 9. ELECTRICAL HAZARDS | <input type="checkbox"/> 18. OTHER FACTORS |
| <input type="checkbox"/> 10. GREASE | |

CLINICAL MANIFESTATIONS UNIT

Percent less than normal in this case _____%

Check involved factors

- | | |
|--|--|
| <input type="checkbox"/> 1. PAIN, TENDERNESS | <input type="checkbox"/> 16. CREPITUS |
| <input type="checkbox"/> 2. MUSCLE SPASM | <input type="checkbox"/> 17. SUPPURATION |
| <input type="checkbox"/> 3. LOSS OF MOTION | <input type="checkbox"/> 18. DIZZINESS |
| <input type="checkbox"/> 4. SWELLING, INDURATION | <input type="checkbox"/> 19. ATAXIA |
| <input type="checkbox"/> 5. INFLAMMATION, TEMP. | <input type="checkbox"/> 20. ECCHYMOSIS |
| <input type="checkbox"/> 6. PARALYSIS | <input type="checkbox"/> 21. FATIGUE |
| <input type="checkbox"/> 7. REFLEX LOSS | <input type="checkbox"/> 22. PSYCHONEUROSIS |
| <input type="checkbox"/> 8. NUMBNESS | <input type="checkbox"/> 23. EXAGGERATION |
| <input type="checkbox"/> 9. HYPER-SENSITIVE | <input type="checkbox"/> 24. EYE SYMPTOMS |
| <input type="checkbox"/> 10. CONTRACTURE | <input type="checkbox"/> 25. EAR SYMPTOMS |
| <input type="checkbox"/> 11. ATROPHY, TROPHIC | <input type="checkbox"/> 26. SYSTEMIC SYMPTOMS |
| <input type="checkbox"/> 12. ISCHEMIA | <input type="checkbox"/> 27. HEART AND BLOOD |
| <input type="checkbox"/> 13. GANGRENE | <input type="checkbox"/> VESSEL CHANGE |
| <input type="checkbox"/> 14. LIMP, WALKING AID | <input type="checkbox"/> 28. BONE DISEASE |
| <input type="checkbox"/> 15. SYNOVITIS | <input type="checkbox"/> 29. OTHER FACTORS |

REACTIONARY INTERFERENCES UNIT

(Intangible factors altering future endeavors)

Percent less than normal in this case _____%

Check involved factors

- | |
|--|
| <input type="checkbox"/> 1. REHABILITATION |
| <input type="checkbox"/> 2. LIMITED OPPORTUNITIES |
| <input type="checkbox"/> 3. ECONOMIC HANDICAPS |
| <input type="checkbox"/> 4. LIMITED EDUCATIONAL BACKGROUND |
| <input type="checkbox"/> 5. ADVERSE INCENTIVE TO WORK |
| <input type="checkbox"/> 7. UNFAVORABLE LABOR SITUATIONS |
| <input type="checkbox"/> 8. AGE LIMITATIONS |
| <input type="checkbox"/> 9. UNPREDICTABLE EXACERBATIONS |
| <input type="checkbox"/> OF PAIN OR SYMPTOMS |
| <input type="checkbox"/> 10. OTHER BODY IMPAIRMENTS OR DISEASE |
| <input type="checkbox"/> 11. OTHER FACTORS |

Grand total of above five Physical Disorder Units _____ Percent

TRANSFER TOTAL TO FORMULA ON OPPOSITE PAGE

or arm the maximum loss would be amputation, or 100 per cent loss. First of all, the disabling factors must be grouped into units which provide a ready review as to the importance of all the disabling factors which they represent. All the factors pertaining to the disability must be weighed against the remaining normal.

For the purpose of thorough analysis the disabling factors may be divided into two principle components:

- 1. The Functional Factors of Disability
 - 2. The Physical Disorders found on examination.
- These components may be further divided as follows:

- I. FUNCTIONAL DEFICIENCY
 - 1. Quickness of action
 - 2. Security and confidence
 - 3. Coordination
 - 4. Strength
 - 5. Endurance
 - 6. Safety at work
 - 7. Prestige of physique for employment
- II. PHYSICAL DISORDERS
 - 1. Anatomical mass damage
 - 2. Clinical manifestations
 - 3. Restrictions of physical requirements
 - 4. Restrictions of working conditions
 - 5. Reactionary influences

In order to establish the per cent of disability each of the above units is rated at the per cent it contributes to the disability. Since there are seven units, their sum divided by 700 will give an average rating of the percentage of functional deficiency.

The same process is applied to the physical disorders. All findings on examination are considered and a percentage rating established for each unit according to its importance in the disability. The sum of the five unit ratings divided by 500 is the average disability attributed to the physical disorders component.

The component of function is of greater importance than the physical disorders and is weighed as follows:

Functional Deficiency	75 per cent
Physical Disorders	25 per cent

Stated in formula form the following equation will give the rating of disability:

$$\frac{\text{Function}}{700} \times .75 + \frac{\text{Physical Disorders}}{500} \times .25 = \text{Per cent Disability}$$

Percentage Rule of Severity

Accurate rating of disabling factors, according to a percentage of severity is often difficult. A rule of severity that will greatly aid in correlating the degree of severity with a corresponding percentage is suggested as on the form which is useful as an office record for evaluating disability or for a permanent

record. Application of this rule to each factor of all the units will help to estimate the per cent of disability. (Figure 1)

Example

Let us consider J. T., the case mentioned previously in this discourse. His disability would be evaluated on the basis of the entire left leg in which he had an intracondylar fracture of the left femur, together with fractures of the os calcis, metatarsal and cuboid bones. He is satisfying his employer at his regular work as an oilfield roustabout, but from the disability point of view he certainly is not the man, physically, he was before the injury. In using the medical analysis of disability form we would evaluate his loss of function as follows:

Quickness of action, 25% ; Coordination, methodical movement, or skill, 30% ; Strength, 20% ; Confidence and security in his activities, 20% ; Endurance, 30% ; Safety in his work, 20% ; Prestige of physique, 25%. The sum of these percentages of loss is 170.

For the physical disorders component the evaluation of the five units would be: Lessening of normal anatomy due to excess callous, mild deformity of the leg, articular destruction and loss of bone: 20 per cent.

Clinical manifestations of loss of motion, pain, contracture, atrophy, and limp: 25 per cent.

Restrictions of function on job requirement: slightly limited pulling, pushing, and lifting; moderately limited walking, kneeling, and crawling: 30 per cent.

Restrictions of working conditions would consist of hazardous positions, slippery floors, and machinery which would be calculated at 15 per cent.

Reactionary or intangible factors would be involved only in case his present employer dismissed him. He would have difficulty if he had to learn some occupation other than oilfield work. It is also true that the osteomyelitis of the os calcis is subject to unpredictable exacerbations. The loss of this factor would be evaluated at 15 per cent.

The sum of these percentages is 105.

By applying the formula the rating of disability is now obtained:

$$\text{Functional loss } 170 \div 700 = 24.3 \text{ per cent}$$
$$\text{Physical disorders loss } 105 \div 500 = 20.0 \text{ per cent}$$

Adjustment of relative importance of loss of function, vs. physical disorders

$$24.3 \times .75 = 18.22 \text{ per cent}$$
$$20.0 \times .25 = 5.0 \text{ per cent}$$
$$\text{Disability Rating} = 23.22 \text{ per cent}$$

Thus, a per cent of disability for the leg is arrived at by a regulated method of analysis that fully satisfies the examiner that he has given full consideration to all the disabling factors involved.

606 N.W. Tenth Street



Quiz

for

doctors

AC

you probably know every answer!)

Q. Which is today's most widely prescribed broad-spectrum antibiotic?

A. ACHROMYCIN — it's first by many thousands of prescriptions.

Q. What are some of the advantages of ACHROMYCIN?

A. Wide spectrum of effectiveness.
Rapid diffusion and penetration.
Negligible side effects.

Q. Exactly how broad is the spectrum of ACHROMYCIN?

A. It has proved effective against a wide variety of infections, caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa.

Q. In what way are ACHROMYCIN Capsules advantageous?

A. For rapid and complete absorption they are dry-filled, sealed capsules (a Lederle exclusive!) No oils, no paste...tamperproof.

Q. Who makes ACHROMYCIN?

A. It is produced — every gram — under rigid quality control in Lederle's own laboratories and is available only under the Lederle label.

ACHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle



LEDERLE LABORATORIES DIVISION AMERICAN *Cyanamid* COMPANY PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

Report to the Board of Trustees of the American Medical Association of the Committee on Medical Practices November 1954

TO: MEMBERS OF THE BOARD OF TRUSTEES

We have completed our study of unethical practices and the related public relations problems. The report of our work is attached.

We feel that our analysis of these problems is sufficiently complete to suggest a basis for corrective action. Our report is not a statistical analysis. Interviews were conducted with doctors and patients selected at random in New York, Massachusetts, Ohio, Iowa, and California. Our method of research was qualitative, not quantitative, and the interviewers frequently spent hours with each doctor interviewed in order to get his *real* thoughts and feelings.

Mr. Waterson, our staff consultant, does not recommend spending more money on research. We accept his opinion that further interviewing would produce only repetitions of the results which we have indicated in our report.

We originally requested \$31,000.00 for one year's work. The major part was to have been devoted to the time-consuming and expensive work of research. The second six months would have been given to working out in detail the possibilities of implementation, with a thorough exposition of the various techniques which could be used to translate the findings into actions. In compressing our work into a half year with a budget of \$15,000.00 we were obliged to sacrifice something. Therefore, we acknowledge that the research has been somewhat curtailed and the planning for implementation has been left, for the most part, to existing committees and councils and others who will be called upon to make use of our findings.

One observation from our staff's letter to the Committee seems significant enough to call to your attention. The staff said, "With a promise of anonymity from sympathetic interviews, doctors have revealed their hopes and frustrations, their confusions and their convictions. Many are deeply affected by

economic insecurity, by public hostility, by conflicts within the profession, and by the feeling that they are not accurately represented by their leadership."

We should like to have the Board of Trustees of the American Medical Association express to the California Medical Association appreciation for the services of Mr. Waterson, who is under full time contract to that Association. The California Medical Association received virtually no reimbursement for the loan of Mr. Waterson's services. We want the Board to know that we also appreciate the fact that Mr. Waterson received no remuneration for the considerable amounts of his own personal time which he contributed to this work. We would also express our appreciation to Lois Chevalier for her contributions of intelligence and research ability to our work.

Ernest Dichter, Ph.D., President of the Institute for Research in Mass Motivations, was associated with Rollen Waterson Associates in the staff work for the Committee.

The AMA Headquarters Staff has been splendid in their interest and complete cooperation.

All of the Committee felt the great seriousness of our project and gave freely of their time and talents.

Respectfully submitted
COMMITTEE ON MEDICAL PRACTICES
American Medical Association
Felix L. Butte, M.D.
John S. DeTar, M.D.
James Q. Graves, M.D.
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SECTION I

Inequity of fees and the "Planned Economy" in Medical Practice

A. *There is general agreement among doctors that there are greater financial rewards for surgery than for medicine.*

The survey of physicians' incomes prepared by the United States Department of Commerce, in collaboration with the Bureau of Medical Economics of the AMA (1950 figures), gives income figures for medical specialties and surgical specialties. Internists, by far the largest group of strictly medical specialists, have a median income of \$10,944 a year. General surgeons, the largest group in the surgical specialties, have a median income of \$15,389 a year. And when a pediatrician (\$10,695) compares himself to a neurosurgeon (\$24,500) there is certain to be feeling.

The attitudes of general practitioners cast an interesting light on this discrepancy in compensation. In the East, where surgical privileges in the hospital are difficult for a general man to obtain, the general practitioner and the internist talk alike.

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A general practitioner says:

Take a child with an appendix. You make the diagnosis, call the hospital, arrange for the admission, maybe for an ambulance and you get five dollars. You refer the case to a surgeon who takes the appendix out in fifteen or twenty minutes, sees the child four or five times afterwards, and gets \$150. I think the differential is too great.

An internist says:

I think it would be much easier to do four tonsillectomies and make \$400 instead of doing one complete difficult diagnostic work-up for \$25.

Whereas the West Coast general practitioner who, more often than not, has surgical privileges, says, for example:

... it is a funny thing, but the surgical lectures were much better attended than the medical lectures were. Yeah, more GP's seem to be interested in surgery because probably they think there are bigger fees in surgery—and maybe there are. It's very, very difficult to take some strictly medical problem and conquer it and then get \$250 or \$350 for a fee.

Both surgeons and non-surgeons agree that the surgeon's earning period may be shorter. Both agree that with some kinds of cases his day's work may be more exhausting, both physically and emotionally. Yet the surgeons themselves are often uncomfortable about the discrepancy in fees.

A general surgeon says:

You know, you feel terribly sorry, terribly sorry, when you always get the big fees and the attending man may only get an assistant's fee—you sort of feel that's inadequate for him. He may have made the diagnosis; he may have done all the difficult work in getting the thing worked up. The surgeon comes in and lowers the blade and removes the appendix and gets a \$200 fee . . . I don't think it's entirely fair . . . I really don't.

To summarize, there is general agreement among doctors that there are greater financial rewards for surgery than for medicine. Interestingly enough, there is considerable agreement about the reason for the discrepancy. The doctors interviewed suggested the psychological factors involved with such clarity that very little interpretation need to be added to their own words.

B. Most doctors believe that patients are more impressed with surgical therapy than with diagnosis and medical therapy.

A general practitioner said:

. . . such therapy doesn't have the dramatic appeal of surgery, which, of course, still carries emotional connotations of magic, hoodoo, and so forth and which probably explains why surgery can command and get such high fees.

And the surgeon is conscious of the dramatic overtones of his work:

. . . there is a certain element of the dramatic and the eminently satisfying, seeing the illness begin and suddenly be concluded by a simple maneuver. It's very satisfying. It's the science of therapeutics in its highest form, surgery. You do something that has a beginning and an end and oftentimes the cure is readily demonstrated. And the patient, unfortunately, I think—it's because of our popular education which has failed in that respect—thinks of the doctor as a man in white, the fellow who has a mask on his face . . . and drips from the elbows. And there is something about that which is very attractive to the doctor, too.

This is not to say that internists do not take great pride in what they feel to be the intellectual distinction of their work:

. . . due to the way medicine has been in the past, with the history of the barbers and the blood-letters . . . the populace is conditioned to either being tortured, in quotes, having blood let, or having something to show for what they pay for. After all, we sell them advice, diagnosis, and pills, and how to live. And it takes a particular type of intellect to be able to appreciate this as a superior service.

Likewise the general practitioner has his particular psychological satisfaction:

I think the GP is the core of medicine, the whole of medicine is dependent on him and we as a class do not have "numbers" for patients. We have patients. We are friends of our patients and they come to us with all their problems.

Yet both the internist and the general practitioner feel that the surgeon has an advantage over them in the matter of status with patients and financial reward.

C. Because of the greater financial reward and the higher status with the public, there is intense competition for surgical work.

The intensity of the competition for surgical work is reflected in many ways. No one advises the young surgeon just to open his office and wait. Some doctors say the young surgical specialist should head for the smaller cities. Others say he should try for some kind of association or partnership with an established man. Others say he should perfect himself in one small part of the specialty and be a specialist within his specialty—to give himself a competitive advantage. Some suggest that he find a part-time job in research or in a clinic. Everyone acknowledges that in most cities the young surgical specialist must use finesse, diplomacy, and careful self-promotion to wangle a hospital staff appointment. Many doctors blink at the fact that he may have to do a little general practice in spite of the restrictions of his board.

A general surgeon says:

General surgeons are pretty easy to come by and in a com-

munity of this sort . . . the province of general surgery is pretty well covered. And for anybody to come in and say: Stop sending your surgical referrals to the other surgeons with whom you are working and send them to me—would be—presumptuous.

A urologist says:

My field is generally overcrowded. I think it is also true of other surgical specialties. With more competition the income is much lower. It causes some of us to lie awake nights wondering how—maybe to get some union work, or some lodge work, and maybe some clinic work for contracts, teaching institutions—.

And the general practitioner who fights to keep his own surgical privileges observes the difficulties of the surgical specialist:

Many fields are becoming overcrowded. There are too many surgeons with not enough to do and the GP is bona fide competition.

Another general practitioner says:

It's a lot easier, I presume, to be a surgeon and pick up a \$300 fee for an hour's work, but you don't just walk into two or three surgical cases a day. After you've been in practice twenty years you might, but you spend long lean years waiting for one a week. It isn't all peaches and cream by any means.

These assumptions—which are more or less taken for granted—speak for themselves. We have found that little statistical work has been done to measure the intensity of the competition or to prove the hardships that this competition entails for doctors doing surgery. But it seems to be accepted as common knowledge.

One young surgeon made a survey (the results of which were published under the name of J. Ray Thomas, M.D., in *GP*, May, 1954) which bears out these assumptions. He sent questionnaires to a small group of young surgeons and from their response concluded:

It seems to me . . . that most young surgeons are well capable of and would like to do at least 250-300 major surgeries annually. This amount of surgery would justify the limiting of their practice, their long years of training, and would help to perfect their surgical judgment and technic. There are, however, only four (11 per cent) of these doctors who reported doing more than 250 majors a year, and only seven (20 per cent) who are doing more than 200. In fact, 36 per cent of this group of surgeons who are in their third to fifth full year of practice are doing less than 100 major operations a year. This must be interpreted as a poor batting average for medical productivity and utilization of available skilled medical services.

D. The economic aspect of this competition is not now free and open but is at least partially regulated by (a) enforced restrictions by specialty boards and by (b) rules in some hospitals which discriminate against general practitioners as a group.

The rules and regulations, which were established by the specialty boards for the purpose of fostering high standards, have come to be regarded by many doctors as restrictive. At least the economic consequences of the attempt to enforce the limiting of a specialist's practice are considered by many doctors to be an imposition. These doctors usually assume that the current policy of the Boards is to make examinations increasingly difficult in order to decrease the number of surgical specialists.

Thus the conflicts among doctors over who should do surgery are deadlocked partly because rules and customs enforcing a limiting of a surgeon's practice are not acceptable to many surgeons.

It is evident that the surgical specialist is handicapped economically because he is arbitrarily cut off from the source of supply of his work. Some surgical boards frown upon his ever doing any work outside his specialty; and most of the surgical boards expect him to limit his practice during the difficult first years of his practice when he is in debt and has a growing family.

A general surgeon said:

And as they get out of their training and out of the army, they start . . . under the handicap of nothing to do . . . what might be called the routine stepboards (stepping stones) of medicine . . . they go either one of two ways: either they break the rules of their board qualifications and do other things or a few of them remain Simon-pure and struggle very hard. Many of them are able . . . because of . . . independent incomes.

Another surgeon said:

(Building up a practice is) very much slower if the individual stays within his specialty . . . does not do—as so many do—non-surgical work in addition . . . I would say that very few actually stick with their specialty although they claim to.

An urologist said:

In specialties one usually relies on other physicians to refer patients to them, whereas in general practice one relies on patients . . . The general practitioner is more independent professionally and financially than the specialist. The specialist wouldn't dare speak his mind too often . . . one must be careful about his choice of words. It's an uncomfortable situation.

The survey made by J. Ray Thomas, M.D., gives reinforcement to what our interviewers were told. Those young surgeons who had been in practice less than three years had an average ratio of 24.2 office calls per surgical operation. Those who had been in practice five years had only 13 office calls per surgical operation. The author concludes: "Although most of them would never admit it, for reasons of pride, prestige, specialty ratings, it is obvious that there is of necessity, not of choice, considerable general practice being carried on in many general surgeons' offices."

The arbitrary freezing out of all general practitioners from the hospital, where this has occurred, also appears to have intensified the conflict over surgery.

A non-certified surgeon said:

I can still have full surgical privileges in any hospital on an equal par with a member of the College only because I have been practicing long enough. If I were starting practice now I would be forced to join the College or take the American Board in order to do the type of work that I am now doing. I would have no choice. I feel that the restrictions on the doctor are growing. In general I don't feel that it has meant any advancement in the practice of medicine from the standpoint of either the patients or the doctors.

A Board-certified man said:

And I think there is altogether too much regulation—in assuming power and in trying to dictate to the various hospitals and to the various doctors what they should and should not do . . . I may be wrong on the subject but I just feel that a man that has received training and had a good education and has had good experience should be allowed to do what he thinks he is capable of unless he gets into trouble. Then he should be stepped on and not told because he isn't a member of the Board of so-and-so that he can't do certain types of cases.

In short, the surgical specialist is, to some degree, frozen out of the general practice of medicine, and the general practitioner is, to some degree, frozen out of the practice of surgery. Each group resents the freeze-out. And without treating the question further for the moment, it is evident that these two attempts at a "planned economy" for medicine have accomplished little to relieve the conflicts and dissension which surrounds the competition for surgical work. In fact, there are those who say that, whatever the non-economic motives behind these restrictions, i.e., higher standards, more intensive application to the complexities of one's field, the end doesn't justify the means.

To sum up: There are greater financial rewards for surgery than for medicine. There is higher public status for the doctor who does surgery. There is more intense competition among doctors for surgical work. The economic aspects of this competition is not now really free and open, but is at least partially regulated by arbitrary restrictions.

E. All these factors combine to create a climate which encourages unethical practices.

Interestingly enough, the discrepancy between medical and surgical fees was recognized by organized medicine as a basic cause of unethical practices over 40 years ago. The Judicial Council of the AMA, directed by the House of Delegates to investigate the secret division of fees, reported in June, 1913:

In the last twenty-five years surgery has developed to such an unprecedented degree compared with its former possibilities that it has entirely changed its relative position to other branches of medicine. Surgery, per se, compared with internal medicine today, as it appeals to the lay mind, is practically the difference between the abstract and the concrete. Surgery is concrete service of a visible, definite kind, easily appreciated by the same

average intelligence which fails to appreciate any abstract service however valuable.

The lay mind sees and appreciates it (surgery) and is therefore willing to pay for its performance as the only practical return that can be made for the blessings that it gives.

. . . The fees therefore of the physician have lagged behind those of the surgeon and the worldly rewards in internal medicine are not as great as those of surgery. More than that, the rewards given to physicians are on the average given more grudgingly than to the surgeon. The surgical fees are enormously greater than they were twenty-five years ago; medical fees still remain practically the same . . . Oftentimes . . . physicians giving their time, draining their personalities, giving of all that is in them, find that the sense of obligation to reward them for their service diminishes in direct ratio as a feeling of friendship from their patient increases, with the result that they cannot collect a fee for an honest, difficult, scientific diagnosis which results in the life-saving operation for their patient, while the surgeon who does the mechanical operation readily collects a relatively large fee.

. . . It is easy to understand, therefore, that under the strain of the struggle for existence, the physician, seeing his more fortunate brother obtain relatively large fees for apparently easier work, should be filled with envy and his sense of moral obligation and his duty to his patients should suffer in consequence. On the other hand, taking into account the competition among the surgeons for opportunities to work, with a desire to increase their clientele and income, it is easy to understand how they have stifled their consciences and have yielded to the temptation to bid for the work of their wavering confreres . . . The younger surgeon, desiring to start, will make his bids to split his fees and will gain a bigger clientele and become more quickly established. Physicians unable to collect their fees will endeavor to throw the responsibility on the surgeon and obtain through him, as a partial collector from their clients, the moneys which they should collect for themselves directly from their patients. The result is demoralizing to them both. The patient is brought to the surgeon who will split off to the physician the greatest percentage of his fee irrespective of whether or not that surgeon is the best one to perform that operation on that given patient. Furthermore, the temptation soon arises to operate unnecessarily that the surgeon may have his fee and that the physician may obtain his share. From what at first seems but a harmless endeavor to collect part of uncollectable moneys due him for his work, the physician may find himself in the unhappy position of having degenerated into one who dishonestly is exploiting his patient for an unnecessary operation . . .

In the intervening 41 years since this report was written, anyone who has talked with doctors about this problem has heard the same reasoning. No doctors in this present survey confided in the interviews in so many words: I split fees with Dr. X because this is the only way we can get along. In fact, doctors spoke heatedly about their conviction that fee splitting is wrong. But almost no doctor failed to mention some kind of justification for the fee splitter. And many doctors said they thought that fee splitting should be "legalized." To read through some of their comments leaves the impression that they feel: Things being the way they are what can you do about it?

A general practitioner said:

The young doctor becomes a victim when he tries to establish himself in practice. The young surgeon who tries to set himself up in an area very soon finds himself without a referral reservoir unless he is willing to split the fees with the referring practitioner.

A radiologist said:

. . . the older doctors make no effort to take in younger doctors and so force them into fee splitting to make a living . . .

A surgeon said:

There was a ghost surgeon here in town . . . he would split the fee right down the middle and . . . he did ghost surgery for many men. He was a darn good surgeon, too! I don't know what happened to him. I suppose economics is the reason for it—the difficulty of making a living.

A general practitioner said:

I never engage in fee splitting myself, but I know it goes on and I can't honestly say that there isn't some justification for it . . . I can't help but feel that something must be worked out eventually to balance it out in an open and aboveboard manner.

Another general practitioner said:

A friend of mine, a young surgeon just out of training, told me not long ago that that was his situation . . . Patients aren't just standing in line waiting and it takes time to build up a following . . . The ideals get a bit tarnished or rubbed off when the economics of making a living for a wife and family hit you. So far as fee splitting is concerned, it's always been with us. I went back to Canada last year and it was still going on there. It's also going on here, and not necessarily the young surgeons, either. I know some chiefs of staff, top men and very competent surgeons, who have their little coterie of "boys" as they call them, with fee splitting arrangements between them.

An OB Gyn man said:

A man of good training who can't get hospital privileges . . . he may not desire to do it (ghost surgery) or be proud of it, but it may be the only way he can use his skills.

. . . it is simply a question that when a practice is so widespread, as it is at the present time, and there are so many young surgeons who have a tough time getting surgical cases, the economic factor overcomes the ethical factors . . .

An orthopedic surgeon said:

Of course you can, if you want to, on the first day you open up your office have it full of patients. Or you can wait, day in, day out, for the patients to come in. In the long run, being honest pays off. But it's tough in the initial stages.

Another general surgeon said:

I do feel this, that the economic factors are the strongest points. Where the young physicians are able to earn a living, that they are not strongly tempted to develop this type of practice (unethical). They probably would not even think of it if they were able to earn a living.

Another surgeon said:

I feel that a GP who has had ample training to do hernias or appendices has just as much right to do them as has a member of the American College. I think tendency toward forced restrictions is as much responsible for so-called fee splitting and poor medical ethics and poor medical relations than anything else. Or, if you want to put it a little differently, I think your American College of Surgeons probably, in an honest effort to raise standards, has done more to lower them than anything else by the creation of improper restrictions, by setting up standards that are too rigid as to who is qualified to do what.

F. *The relief of these pressures should make it easier for more doctors to maintain higher ethics in their practices.*

Actually, none of the conditions which create a climate favorable to unethical practices are immutable. The Committee believes that all are susceptible of change, if medicine wants to make the effort. This is not to say that these conditions can be altered overnight or that changing them would automatically result in the elimination of all unethical practice. However, it is evident that the existence of these conditions creates pressures toward unethical practices, and the relief of these pressures should make it easier for more doctors to maintain higher ethics in their practices.

The greater financial rewards for surgery.

The interviews with doctors show clearly that all fees are a matter of tradition and public acceptability. When asked how he set his fees, every doctor, no matter what his field of practice, said: "I asked around the community and found out what other doctors were charging." If the interview pressed the question further, they all admitted that they had no idea where the fees originally came from—and some of them were a little annoyed at being asked what seemed to them to be a foolish question! A tonsillectomy is worth \$75 because that's just what it's worth! (The interviewers concluded that doctors display little scientific curiosity on the origin and basis for their fee structure.) The exception to this lack of interest and curiosity comes to light where doctors doing one type of practice feel that their financial rewards are below those of some other group—the internists have given considerable thought to why the surgeons are better paid.

Some indications of an approach to the problem have come to light. There is evidence, first of all, that the surgeon, who puts his price tag on only one part of his work, is underpaid for the rest of his time. His position is something like that of a housing contractor who charges for the building and throws in the services of the architect free.

As one surgeon said:

. . . the actual time taken in operating by a surgeon is a small proportion of all the time that he spends with his patient . . . surgeons spend 50 per cent or 60 per cent of their time rendering some kind of psychiatric treatment, so that even as highly specialized an individual as an orthoped, dealing with low back pains and sciatica, spends a good deal of time allaying his patients' undue fears and helping them in an emotional way . . . Then as far as diagnosis is concerned, there is an old adage that a surgeon is just a good clinician who operates, and certainly another 30 per cent of his time is spent with the problems of clinical judgment and diagnosis and only a small proportion of his time is actually spent in the operating room performing the surgical feat that he is expected to do.

As one internist put it:

There are many general surgeons practicing \$5 internal medicine in their offices, anticipating recouping their losses on the group of patients who can eventually be operated for a fee of several hundred dollars. This device is known in the chain grocery store as the "loss-leader"—the item advertised and sold below cost to bring the traffic in. General practitioners who do surgery recognize that their medical practice is used to feed their surgical practice and frequently their surgical practice subsidizes their other work.

A further indication of the one-sided way in which the surgeon measures his own worth is seen in the relative value scale produced by the American Association for Thoracic Surgery. In this scale the thoracic surgeons have set up six basic factors which should be evaluated in determining a fee and assigned to each factor a maximum number of points. Each procedure is rated and points for each factor are assigned. Under this system, each point can be given a monetary value, and while fees may differ from community to community, the *relative values* of different procedures are standardized. The maximum possible points for any one procedure is 77. Out of a possible 77 points, the maximum which can be allowed for pre-operative work is 5. Pre-operative work is defined as:

. . . proper or sufficient history and physical examinations and other studies indicated by the specific case; study and evaluation of medical reports, x-rays, electrocardiograms, laboratory studies, etc. It also includes the time spent in consultations with other physicians; discussion with patients and relatives regarding the proposed surgery; time spent in preparing reports and in making any necessary arrangements which may be required for the case.

In allowing 5 points for this enormous block of work, out of a possible 77, it would seem that the thoracic surgeons are selling themselves short—and by implication selling short all their colleagues whose practice of medicine is largely concentrated within this range of activity.

Practically all the surgical specialists who were interviewed gave lip service only to the custom of enforced restriction of practice. A sample of their remarks shows that many of them resent—or ignore—the rules, written and unwritten, which keep them from being doctors first and specialists second.

One said:

I did some general practice to get started. I happened to be certified in general surgery, but you've got to build up a certain amount . . . I don't know about other specialists, but I feel a specialist must have that leeway until he takes care of his overhead.

Another Board-certified specialist said:

I can't see if they're limiting their general practice and still doing a majority of specialization—I still don't think that is something against them if they do take a general case here and there . . .

A general surgeon said:

They start out with high ethical ideas of the type of practice they're going to do, and you soon find them taking care of all types of cases . . . it is difficult for them to meet the high ideals that the Boards set up for them. Some of them get very depressed about it—very bitter toward everything.

Another point of view:

. . . as doctors grow up in the world they should be given adequate opportunity to do surgery and the ones who emerge as specialists in surgery should be the ones who are qualified, rather than trying to take individuals immediately from the school and make them immediately highly qualified specialists . . . When their performance is adequate, then their certificates should

be granted, and not the other way around. Then we would have mature men—mature enough in their fields and mature enough in medicine so they would not even dream of resorting to fee splitting, because they wouldn't need it badly enough to accede to it. This would lead to no necessity for harsh rules . . . for committees . . . a "Hatchet committee" and no need for gestapo tactics in medicine . . . I think that under those circumstances, why, the tendency toward fee splitting which has grown so acute lately would be remarkably easy to manage. As for the argument that a man should devote his entire time

WE THEREFORE RECOMMEND:

1. That a subcommittee of the Medical Practices Committee be created to begin work on a relative value scale for the whole of the practice of medicine and surgery. Such a subcommittee could begin with the relative value scale produced by the Thoracic surgeons (the only group which, as far as we can determine, has produced such a scale) and develop and broaden this approach, calling in as consultants representatives of general practice and all the specialties, as well as using the services of such non-medical advisors as were needed.

The scale which they would produce would be in points, not in dollars. It would be an indication for both doctors and the public of the proper relation between fees for various medical and surgical services.

WE FURTHER RECOMMEND:

2. That a program of public education on the value of diagnostic and medical work be fostered by the AMA Public Relations Department to increase public appreciation of non-surgical work.

We also recommend:

3. That the AMA communicate to the specialty boards the findings of this survey, encouraging the boards to reappraise the value of their regulations restrictive on the practice of those seeking or holding board certificates (with consideration of the removal of the restrictions in keeping with good medical practice);

4. And that the AMA continue to use its full influence to discourage the arbitrary restrictions by hospitals against general practitioners as a group, regardless of their qualifications as individuals.

Closing Remarks:

We can see little hope of curing fee splitting by superimposing more oaths, rules, restrictions, regulations, and inspections. The Columbus Plan has the advantage of providing the doctor who *wants* to stop fee splitting with the psychological support of a like-minded group and the negative incentive of avoiding

to his specialty in order to master its complexities and keep abreast of new developments, this has been rather convincingly answered by those who point out that the idle young surgeon is not necessarily spending his non-productive time in studying. He is more likely to be doing his own bookkeeping or building his wife a kitchen cupboard because he can't afford to hire these chores done. As one young surgical specialist said frankly:

The first year in practice I lost \$1,800, and the next year I broke even . . . I spent those two years with photography as a hobby, to kill time between patients.

Its existence would be of interest to underwriters of health insurance and to all organizations, both medical and non-medical, which are concerned with fee schedules. As it proved its usefulness and as more and more people became aware of it, the economic inequities which foster fee splitting would probably decrease.

We are aware in making this recommendation that we *may* be suggesting either a rise in the overall cost of medical care or a net reduction in that portion of the surgeon's fee which covers his actual operating time. But the scale will not be a fee-schedule, and the dollar-value assigned to the points will determine whether the scale raises the total cost of medical care or changes the fees to provide more appropriate recompense for medical work.

exposure. A system by which the name of the operating surgeon was made part of the data on the patient's hospital bill would probably eliminate ghost surgery in cooperating hospitals. But there is a long human history of broken oaths and regulations, where law does not conform to the realities of a situation.

The existence of a relative value scale, the encouragement of higher fees for diagnostic and medical work, and the removal of enforced limitations on practice would undoubtedly result in changes of the patterns of practice. Many doctors who are pleased with their practices as they are may prefer not to see changes. However, we have ascertained to our complete satisfaction that the financial inequities and the attempts to departmentalize medicine within rigid, artificial boundaries are basic causes of unethical practice. It seems clear that there is a choice between the kind of underhanded subsidy of diagnostic and medical work through fee splitting, and an open re-evaluation of fees. There is a choice between a divided profession with arbitrary unrealistic rules which many doctors surreptitiously evade, and a profession in which each man is free to find his own place without resorting to subterfuge.

SECTION II

Unethical Practices and Public Hostility Toward the Profession

As the Committee worked on its assignment it became evident that the unethical practices we were told to investigate and the unfavorable publicity about these practices do not exist in a vacuum. Public attitude toward the profession is the measure which editors use in deciding to buy and use these derogatory articles. Beyond that, doctors in their daily practice are influenced by the public's emotional reaction to the profession and by the public's demands and disappointments. Therefore, public attitudes are both cause and result, too thoroughly intermingled with the entire problem to be disentangled from it. Thus we found ourselves in the midst of a study of the total public relations problem of medicine.

Some of the causes for the public's disaffection with medicine are so well known that we will not report them in detail. For one thing, the leadership of the American Medical Association is well aware that patients regret deeply the loss of personal element in the doctor-patient relation. The AMA headquarters staff has worked diligently on another cause—trying to get doctors in the county societies to take collective responsibility for the availability of medical care—through emergency call service and guarantees to the public. Certainly everyone is aware of the public's feeling that health insurance today is not adequate to meet their needs and their feeling that medicine should take the lead in making possible greater certainty of coverage. Or-

ganized medicine on various levels, with various approaches, is trying to find solutions for these problems. This committee can only emphasize the urgency which attaches to the solutions. For there is no question that public hostility toward the medical profession is mounting rather than diminishing.

Beyond these well known aspects, there seem to be some other fundamental public relations problems which our work has revealed—problems which tie in closely to unethical practices and adverse publicity. The two which seem clearest to us are treated below.

A. The public needs to know to what degree medicine is an exact science and whether doctors are supposed to be infallible.

The genesis of the notion that doctors are infallible is a complex one which we can not do more than hint at. Obviously, medicine as magic in the primitive society was not permitted to be less than a sure thing. If it failed to accomplish its objective, then someone had neglected to perform the ritual correctly. And if the medicine was actually a function of the religion, then to doubt it would have been to doubt the gods.

Today the word "science" has some of the connotations of magic in the non-scientific man's vocabulary. "Science reveals" a new substance to make his teeth whiter, a way to estimate his fitness for a job, a chance to cruise around the solar system. It is not easy for him to understand where science leaves off and science fiction begins. His science fiction expectations may become attached to his doctor who is the only real live scientist he knows,—a dispenser of "wonder drugs" and a performer of "life-saving operations."

Thus the doctor is a priest—in the old belief and in the new. He works with forbidden things, things beyond most people's knowledge. As one patient put it:

I respect doctors. I think they are like ministers. And it's hard work and a lot of grief. I wouldn't listen to troubles and work in blood the way they do.

And another patient said:

I think the only time a doctor should charge a very big fee is when they cut or when they work on your head. If your mind, your brains are mixed up in the operation that's when you can't play around. The doctor is a real doctor then. He doesn't have to bow down to anything. Only he can do what he is doing. Who else can put their fingers in your head and not kill you?

The doctor himself has a difficult time adjusting to his "differentness." It creates conflicts in his attitude toward his practice and in his relationship with his patients. He thinks that in order to keep his patients' confidence he must live up to a superman role, and build the illusion that medicine is an exact science and doctors infallible. Yet if the medical profession officially, or the individual doctor, promotes illusion, they are immediately involved in a complex of ethical problems.

As one doctor said:

If the patient were to look upon the doctor as a man who is well-trained in his field and to whom he can come for help, but who is certainly not omniscient or unfailing, we would probably have better results from medicine. It would also probably have less unethical conduct on the part of the doctors who may be unscrupulous. This is a very delicate situation to discuss because it is certainly good to have unquestioning faith in the ability of the doctor, because without faith a lot of healing could not be done. The situation still lends itself to a condition where many doctors might take advantage of the situation. I have very often thought, in connection with this, that while the patient is somewhat to blame for this attitude, the medical profession is more to blame for it. They have set themselves up as being superhuman but they have not taken the trouble to screen their people well enough to admit to practice only those capable of handling such situations.

Another one spoke of the difficulty of competing with the "doctor next door" who is willing to use the present-day equivalent of magic:

... patients have the idea that penicillin is a great medicine and they should have that for everything, including colds. And a patient will have a bad cold and come into the office and want a shot of penicillin. It's kind of hard sometimes to get around that. It's a matter of deciding sometimes of having that patient go next door to some other doctor or to go ahead and give that shot of penicillin. To satisfy them. And you may use far better medication for that cold, but because of psychological elements which are always so prominent, the medicines don't work

out. So they either come back and want that shot of penicillin still, or they go off to some place else.

Another says:

Now take the doctor that double-talks a patient. He isn't faking when he does that instead of telling the truth. If you tell a patient that you don't know, he loses faith in you. I've seen a patient change from doctor to doctor until he found one that lied.

Another doctor says:

Of course a lot of people aren't happy unless they have an operation, particularly those women in the menopause. They think they suffer everything under the sun and that everything is wrong with them. I would like to see rigorous inspection of these hospitals and patients by the government. It would stop a lot of this unnecessary surgery that ruins people.

The question is difficult to deal with because the issues are not clear cut. Faith in the doctor and in the treatment is a factor in healing. Patients *do* create pressures by being really personally dependent on their doctor or by demanding the exorcism of surgery. Less thoughtful doctors who exploit these attitudes in patents offer unfair competition to other doctors. If the profession permits itself to slip into a belief that all patients have to have their doctors appear infallible—and their drugs "wonder" and their cures "miraculous" and their operations "life-saving"—they are placing themselves in a vulnerable position, because they cannot deliver the goods.

Louis Regan, M.D., in his book, *Medical Malpractice*, gives considerable attention to the "overoptimistic prognosis" as a starting point for many malpractice actions. In his conclusions on the general approach to the problem of malpractice suits, he says:

The public should be informed as to (1) what constitutes malpractice, and (2) how really few cases of actual malpractice occur. There should be better understanding, too, of the physician's duties, his capacities and limitations, of what may reasonably be expected of him.

There is evidence in some of the interviews that doctors may be coming to believe that the aura of infallibility and the myth of the exact science are indispensable to the practice of medicine and therefore to the public welfare. They may be depending on each other collectively for protection in a false position. One doctor said, probably without realizing the full implication of this statement:

If there is anything about the practice of medicine that was—oh—mechanically accurate—what I'm trying to say—if there was one definite way of doing a procedure, that anybody could be trained in a short time to do those procedures in a correct and exact way. But that condition does not exist. If we were dealing with a machine, as a mechanic, such things might be possible. But we're not dealing with machines we're dealing with human beings. I think the matter of doctors banding together to protect each other—I think that is probably as much a part of the art of the practice of medicine as any individual doctor talking to his patient.

And another doctor analyzed it:

One of the things I noted which I think is of extreme importance in terms of how physicians behave and what motivates them to behave as they do—I think it is fairly termed a god-complex, I think I started medical school, and even into my internship, in just acting in more or less the average way—and by virtue of a couple of experiences in my internship—I had a bit of this knocked out of me. In terms of promising patients something. Behaving as if I knew what the outcome was going to be. And finding out that it isn't always so. And finally coming to the conclusion that really all I could do was the best I could do and couldn't guarantee anything—except my own personal interest and effort to do all I could do. . . . and yet it's what people want. Very much. And that's fair enough. That's their own need. And somehow that need needs to be treated. Really, it only runs afoul in terms of any harm to the patient. When the doctor really feels he is God's right hand man . . . It may have something to do with the general . . . antagonism toward doctors . . . So many of them behave as though they knew the answers, and people somehow know they don't. People generally know.

The doctor who says "If you tell them you don't know, they lose faith in you" is not looking far enough ahead. He forgets that if you *don't* tell them and *they find out*, they not only lose faith; they are disillusioned and even vindictive. Magazine editors

whose business it is to gauge public response and thereby build circulation will not hesitate to exploit this bitterness, until the practicing physician may never know, when he approaches a treatment room door, whether the patient on the other side thinks he is a god or a crook.

The good doctor doesn't want to be either.

One patient we interviewed said:

My doctor works with the great forces, with God. And when you think of the miracles they do! When he can do such things as hold your heart in their hand . . . I sort of compare a doctor to my religion.

The good doctor does not take this only as a personal tribute to himself. He hears such reverence with humility.

Some disillusioned patients said:

You know a lawyer will defend you in court for no dough, but afterwards he doesn't strut like a god because he did it. Doctors are needed to keep you well—but they think too much of themselves.

They pass themselves off as being a part of a loftier profession . . . Other endeavors—where there is just as much service given—give it with more understanding and plain honesty.

They ought to stop selling doctors like they sell Rice Crispies. I'll take the Rice Crispies. At least I know what's inside matches the label.

One who was perhaps more balanced and realistic said:

When I put my case in a doctor's hands, I want the responsibility to be his, not mine. At the same time, I do object to that kind of a doctor who will not tell you anything and who wants you to trust him for everything. I think most of us are not morons, and while we trust the doctor, nevertheless, we also like him to trust us and to believe that we can understand something about it and that we will cooperate better if we understand why. I trust the doctor more who trusts me more and tells me all about it—what his limitations are, as well as what are the limitations of medical science—instead of 'never mind, I'll take care of it'!

The confusion and ambiguity make it difficult for doctors to practice according to their own highest ethical standards. Furthermore, they lay the groundwork for intense public reactions against the medical profession.

So much has been published in the press about scientific advances in medicine that it has led many to expect all sorts of spectacular results which are not borne out by experience. Perhaps organized medicine should begin to emphasize this fact. Perhaps the official attitude of organized medicine should be patterned on something more nearly like the classic humility of the old country doctor, who often said, "I have done all I can, we must leave the rest to God."

B. The public and the profession needs to understand at exactly what point the doctor can be expected to subordinate his normal self-interest in order to safeguard the patient's vital interests.

The concept of the dedicated profession probably derives from the ideal of the priesthood. It is a group of individuals, set apart from the rest of society, guaranteed by society a "living," expected to perform, in return, a function of completely selfless service. The clergyman, the social worker, the research scientist, and the teacher seem to the public to come nearest to meeting this rigorous standard today. The public supports an institution, either private or governmental, the institution gives minimal economic security to these professionals, and the public receives the professionals' service without ever entering into a direct financial transaction with them.

There are strong indications that the public expects the doctor to show a similar dedication in all his relationships with patients, to forego any thought of self-interest. The demands that many people make upon the doctor indicate this—that he should come in the middle of the night without a murmur of complaint, that he shouldn't charge for any of a number of reasons (because he didn't find anything wrong, because he referred me to a specialist anyway, because he didn't cure the ache) that he shouldn't expect to be paid as rapidly as any other creditor. The complaints that this group voices about his nice house in the best section of town and his new car indicate that they feel he has betrayed his dedication.

Some of their disappointment in doctors is reflected in the following negative expressions from patients:

Once I had a doctor and he told me when I called him up: 'It will cost you \$12 to get me out of bed. Are you that sick?' And I said to him, 'After you ask me that, I'll tell you—if it cost me just twenty cents, I don't want you to come out!'

Doctors think they're little tin gods, too. Well, maybe so. I don't sneer at that part of it. They are above and they should be above, but they're out for the dollars. In some ways they show it.

Most people think doctors are money-hungry, that they're not dedicated enough—and so do I. They're losing ground fast with the public—don't forget that Hippocratic oath. That oath is supposed to mean that they will treat you wherever you fall, and people don't believe that any more.

Doctors should be like public schools—they are open to everybody who pays taxes. Now my doctor would just yell if he heard me say his bills are too high. If I did tell him, he'd just tell me that my chickens and eggs are too high. Then he'd go into his spiel about how long he had to go to college. But I don't tell him what our farm cost us or how long it took us to get where we are today.

The doctors get whatever they think they can get, and it's a terrible price for house calls. But I'll tell you, city doctors are worse, and they have those big, high offices to pay for, so they dig you.

I paid and paid—God knows how long! I think the doctor should have given me some kind of a break on it, but he didn't care. All he cares about is that fur coat on his wife's back.

Some doctors get a bad name because they lie to you. They say, 'Oh, don't worry.' And then when the bill comes in . . . it makes you blink.

They're breaking their necks to get into the society column. My wife reads it and it says Dr. This and Dr. That and their wives wore this and wore that. All of it comes out of their patients—patients who have to pinch to go to a movie on Saturday night.

Not all of them are bitter. Those who like their doctor seem to be influenced partly by a feeling that he is more dedicated than other doctors.

As far as fees go, my doctor stands out above the rest, I believe. I know of many cases where, in my own family, there has been a feeling that doctors in general charge too much. When you consider the mass production of drugs, the great strides in medicine, you would think doctors could allow their services to meet the needs of everybody at a fair price. Of course, I have nothing to yak about personally. My doctor is always very, very much on my side.

I found a good doctor here, and was I happy! He got me off the hook. I had been seeing one specialist after another and he said, 'Your sinus (condition) is the result of your troubles. It won't vanish 'til they do, so save your money'. I cut out the drops . . . and all that and later when my troubles straightened out, I got better. There's an honest doctor for you. He could have kept me going in and going in.

It is a fact that doctors' bills today are as high as a cat's back. Now they have been fair to us. But I know lots of times when other people got high bills . . . Now I never had a doctor crowd me for a dollar, but maybe it's only when the doctor knows you they will give you good care and not go after your money.

I told him what our finances were and that I worked and what I earn. I have to take care of Mother. So he said not to worry, he wasn't going to try to make much from me. He likes being a doctor, he said. His office is nice, but I saw him in his car one night and it's only a Chevvy. We're lucky.

The doctor himself is of two minds about the question of dedication and economics. The most typical reaction is: I didn't go into medicine to make money, but I have to make a living. Most doctors in private practice seem to be acutely aware that

they are on their own, that they do not have the kind of minimal security of the professional employed by an institution. Nor do they have the opportunity to build up a capital investment as the businessman may have. They have only time and skill to sell. One surgical specialist expressed it:

Today there is a struggle for survival, as far as economics is concerned. And there's no such thing as a man—no matter how much he does—whether he does \$20,000, \$25,000, or \$30,000 a year—he may live better than the man who makes \$10,000—but in the long run he winds up with little more than the man who just barely ekes out a living . . . the old days where a man used to have a pretty fair income and could save a few hundred dollars a month . . . could become fairly independent—those days are past, with rare exceptions.

* * * * *

. . . if we should lose our practice for some reason such as illness or death, our business is not worth anything . . . It isn't like a man who builds a retail store from the ground up and then . . . into a big business, and if he gets ill or goes away . . . his business goes on. A doctor's practice is absolutely personal, and without him being there to operate, his business isn't worth anything . . . You can't build up a capital investment.

Most of the doctors interviewed display a consistent preoccupation with their economic insecurity. They think about money a lot—about how to increase their income, about the cost of running their offices, about what their colleagues in other specialties make, about what plumbers make for house calls and what a liquor dealer's net is compared to their own. Yet over and over again, they express their distaste for discussing money with their patients, for revealing any interest in the finances of a relationship which they feel is expected to be purely altruistic. One doctor expressed the conflict vividly:

Anyone is worthy of his hire . . . If he does a job he is supposed to get paid for it, but of course years and years ago when we first started out there was an altruistic . . . spirit . . . and, ah, you just hate to talk about money, especially when you save somebody's life but you have got to be paid, and if we had a course in business (sighs) in medical schools I think we would be a whole lot better off . . . Some doctors have gotten around that by having an efficient secretary and they tell her to charge. She sends out all the bills and she knows . . . A doctor is a doctor and he's not supposed to be . . . you know he's next to a priest or a minister . . . so a priest never—ah—personally says anything to you about money. But of course he has got to make enough money to carry on his church and he will say, 'Well, there is going to be a special collection, or something like that. Most doctors are very, very diffident about saying anything about fees. And they've got to live. They've got to pay the rent. If they don't they're no good to anybody. To their family or anybody. They've got to live.

They also express pride in their individualism and are critical of other segments of the population for seeking too much security. Yet, at the same time, they often wish they were free of their own economic insecurities. One successful doctor in his late middle age said at the beginning of an interview:

I think the average man that has gone into medicine has gone in because he feels that he has some interest in medicine, which is of paramount importance. He has an interest in the public and he wants a certain amount of independence that you can't get in any other form of work. In other words, you are your own boss and . . . I think that's what we're fighting for. We're fighting to maintain this independence because we are trying to keep away from being put on panels and social groups and various organizations in which we become employees and not independent thinkers and workers.

Later in the interview, the same man said:

You feel you are doing something—that you're doing something good for the patient . . . And there's a great satisfaction to medicine. It would be wonderful if we could all practice and not worry about economics, in fact I think it would be a great deal better if we were guaranteed a living and didn't have to worry about our rents and raising our children and sending them—worrying about their college expenses—if we had a situation where we could have a certain amount of security and practice—I think—I personally feel that I would be very much happier instead of worrying from month to month about all the bills that accumulate.

And a few of the doctors asked the interviewer to turn off the wire recorder and then said that they thought socialized

medicine was "inevitable" and that they weren't sure, it might be better for the doctors and the patients too, in some ways.

It seems evident that there is confusion in everybody's mind about altruism and self-interest. There is a feeling that the two conflict. This feeling is a source of unhappiness to doctors and a deep-rooted cause of public misunderstanding and resentment.

The doctor, in a culture where money is the measure of success, is not likely to resolve the conflict by becoming a pure altruist. Neither will anyone—doctor or patient—welcome the idea of a completely commercialized healing arts industry. So the conflict has to be resolved in some sort of a compromise.

Chauncey Leake, in his valuable essay, "Ethics and Medical Ethics," discusses the conflict and recognizes the need for a working compromise:

It is interesting that writers on medical ethics have seldom availed themselves of the philosophical analyses of the principles of ethical theory made by recognized ethical scholars. The two chief ethical positions are idealism which stresses the interests of humanity as a whole, and hedonism which emphasizes the interests of individual selves. Hedonism is usually concerned with personal pleasure; idealism, with the furtherance of the welfare of society.

. . . From the Hippocratic oath to the latest revision of the Principles of Ethics of the American Medical Association, it is implied by all the medical-ethical writers that the ideal ends in the interests of humanity are the real bases for their remarks, and that these must be compromised only as little as possible in the interests of self . . .

One can appreciate why the idealism of the medical profession has not been consistently and formally developed as the basis of codified medical ethics. Idealism seems clearly felt by most physicians to be on a higher moral plane than hedonism but as is sadly recognized, true idealism is quite impossible in medical practice under existing conditions of human nature. The physician must live. He owes a debt to himself and his family, as well as to society.

Chauncey Leake reaches no definite conclusions about a way to avoid the necessity for this compromise which could be imposed upon the structure of medicine as it is today.

One clue to a more satisfactory compromise lies in the wording of the first principle of medical ethics, which has perhaps not been taken literally enough:

The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration.

The formulators of this statement did not say that reward or financial gain was *no* consideration. They said it was *subordinate*. And that which is subordinate does still exist.

Our staff has interviewed patients who are not bitter toward their doctors, who see their virtues and their faults.

As one patient succinctly expressed it:

No doctor is going to take care of you for nothing—no reason why he should. He ain't no angel and he's entitled to a decent fee. Trouble is not everybody can afford to pay it.

Closing Remarks:

If the medical profession claims to be a purely dedicated profession, then the public will resent any evidence of self-interest. If doctors could freely and openly admit the existence of medical economics, they at least wouldn't be open to charges of hypocrisy. If they could make a clearer delineation between "prime" and "subordinate," they could begin to resolve their own conflicts and say to the public: our self-interest operates like anyone else's—up to a certain point, the point beyond which its operation would be detrimental to the patient's vital welfare.

To sum up:

From our pilot study there are indications of confusion about the degree of the doctor's dedication and about whether or not he is an infallible practitioner of an exact science. We must find ways for the individual doctor and the organized profession to reflect a more realistic picture to the public. If the public can be educated to expect and to appreciate what the doctor really can deliver, then doctors will be free to carry on their work in an atmosphere which is not so colored with tensions and hostility.

It may be said with certainty that if this confusion, with its concomitant unrealistic expectations and disillusionments, is as widespread as our pilot study suggests, it will continue to contribute to the rising tide of malpractice suits and adverse publicity until corrective measures are taken.

WE THEREFORE RECOMMEND:

That the following conclusions be incorporated in the public relations policy of the American Medical Association:

- A. That the public be informed to what degree medicine is an exact science and be informed that doctors are not infallible.

WE THEN RECOMMEND AS AN ALTERNATIVE:

that the validity of these conclusions be further tested, by developing an experimental program in a carefully selected community.

A close-knit community should be selected, where the local medical society would be willing to take part in the experiment and to put into effect an intensive program of professional and public education, coupled with a proper public service program. Such an experiment could be set up with some degree of exactitude, including attitude testing before, during, and after the program. Control testing could be done in a comparable community. Technical assistance should be sought for setting up the experimental situations and measuring the results.

In the control community, no unusual activity would be undertaken. In the experimental community, the professional group should begin by revealing that it is really interested in the public to which it looks for economic support. All of the minimal public service programs already fostered by the AMA and the more progressive county societies would be put into effect and announced to the public. Beyond these, the professional group would demonstrate its willingness to accept some small personal sacrifice in the public's interest by offering the cooperation necessary to meet the people's urgent demand for broader benefits and a greater degree of certainty of coverage under voluntary health insurance. Hospital staff organizations would be improved to insure proper control of surgery and of standards in general.

Seminars for doctors would be held in which qualified

- B. That the public be informed at exactly what point the doctor can be expected to subordinate his normal self-interest in order to safeguard the patient's vital interests.

If the Board of Trustees does not wish to adopt these conclusions as policy without further study,

persons who have given consultation to industry would help the physicians to improve their techniques of dealing with people, their office procedures, and their business methods. Time would also be given to ways of preventing unjustified malpractice claims. The doctors would also be encouraged to participate in community affairs and assisted to regain their traditional position as community leaders.

All the appropriate local publicity media would be used to improve public understanding of doctors and to develop realistic expectations of the profession. Officers of the society would orient their public pronouncements to the concept of medicine as a developing but not wholly exact science, and of doctors as skilled but not infallible practitioners, with appropriate self-interest up to the point of conflict with the vital interests of the patient. The public would be told at exactly what point their doctors' normal self-interest is subordinated in order to safeguard their welfare.

Prominent and respected lay persons, such as judges and clergymen, could eventually be invited to sit in and to learn about matters of professional organization and about the profession's work to protect the patient, so that they could represent the profession to the public and provide disinterested testimony when the profession is unjustifiably attacked.

Such an experiment would be an opportunity to field-test the validity of the hypotheses and to measure the effectiveness of various correctives, without committing all of medicine to untried ideas. Such a trial run would provide a reliable model from which to construct a national program.

SECTION III

The Disciplinary System of Medicine

At our request, the headquarters staff of the American Medical Association conducted a survey to determine to what extent the county societies are assuming responsibility for the maintenance of ethical standards. Questionnaires were sent to all county medical societies in the United States and territorial possessions, requesting information on all disciplinary actions taken over the past twenty-four months. Approximately one-third of them (1100) returned the forms. While not all counties responded, many of the larger societies are represented.

21 doctors were expelled by these societies

10 for unspecified reasons

6 for illegal acts

4 for offenses against patients

1 for an offense against colleagues

21 doctors were suspended by these societies

9 for unspecified reasons

7 for illegal acts

5 for offenses against patients
79 doctors were censored
35 for unspecified reasons
28 for offenses against colleagues
13 for offenses against patients
2 for illegal acts

This total of 21 doctors expelled in 2 years seems to us to indicate a lack of vigorous activity on the part of county societies in the supervision of their membership. We feel that because of their close professional and personal ties, members of county societies are unable to exercise the judicial and disciplinary functions.

We also requested an analysis by legal counsel of the disciplinary and judicial system of organized medicine as a whole. Mr. C. Joseph Stetler, head of the Legal Department of the AMA has given us a memorandum on this analysis, which follows:

(Interim Report of AMA Legal Department)

The Disciplinary System of Organized Medicine

This is an interim report. It is only intended to reflect the present status of our efforts in analyzing the disciplinary system of organized medicine.

According to a statement dated August 30, 1954, prepared by Rollen Waterson Associates, the Committee on Medical Practices

has adopted as one of its working hypotheses:

that the AMA and its constituent associations and component societies are in some respect, not discharging the responsibility the AMA assumed to maintain medicine as a profession. (page 12) (Emphasis added.)

It seems necessary at the outset to define the relationship of the American Medical Association to constituent associations and component societies. The statement in the hypothesis that the "AMA is not discharging the responsibility the AMA assumed" might be interpreted by some to indicate that organized medicine consists of *one* basic association—that the constituent associations and component societies are no more than divisions and subdivisions.

Technically and constitutionally, that is not the case. Article I of the Constitution defines the American Medical Association as "a federacy of its constituent associations." A "federacy of associations" may be defined as a compact or league of *separate* sovereign associations having a common interest: The State medical associations had no more intention of divesting themselves of independence when they organized the American Medical Association at Philadelphia in 1847 than the Colonies when they met for a similar purpose to hold the First Continental Congress. The independent character of the State associations is mentioned here because it could become an issue in any effort to adopt and administer an active nation-wide program of discipline.

Although the constituent (State) associations may have a valid constitutional claim to substantial independence, the same does not hold true for county or district medical societies. Article IV of the Constitution reads:

Component societies are those county or district medical societies contained within the territory of and chartered by the respective constituent associations. (Emphasis added.)

Unlike State associations which are *not* chartered by the American Medical Association, the county medical societies are chartered by and derive their existence from the State associations and are not directly linked with the AMA. Fundamentally, the State association is the fountain of authority through which medical practitioners (who are members) may be policed. The chartered county society, as a general principle, may exercise only such powers of discipline as the State association may see fit to delegate. But the State association in turn does not receive its disciplinary powers from the AMA.

It appears, generally, that the constituent associations have delegated (either directly or indirectly) most disciplinary functions to the county societies. Any planning to initiate a more effective system of discipline must recognize the fact that disciplinary functions are highly localized and any attempt to assume aggressive leadership in effecting changes in the present system is likely to meet with constitutional and other obstacles.

Chapter IV, Section 1 of the Bylaws, which deals with disciplinary action, states:

ACTIVE AND ASSOCIATE MEMBERS.—

In all controversies between a Member and his component society or constituent association, an appeal may be made to the Judicial Council on questions of law and procedure only, but not of fact. The appeal shall be perfected within six months following the date of decision by the constituted authority of the constituent association in question. In addition to such disciplinary action as may be taken under the constitution and bylaws of the component society and constituent association to which the Member belongs, the Judicial Council, after due notice and hearing, may censure, suspend or expel any member of the American Medical Association for an infraction of the Constitution or these Bylaws or for a violation of the Principles of Medical Ethics. (Emphasis added.)

The portion of Chapter IV, Section 1, beginning with the words "In addition to . . ." is quoted at page 14 of the Waterson statement of August 30, 1954. Read alone, it may be interpreted as conferring *original* disciplinary jurisdiction upon the Judicial Council. But read in context with the preceding portion of the section, we believe it only empowers the Judicial Council, in *appellate* cases, to censure, suspend or expel any member of the AMA for an infraction of its Constitution, Bylaws, or Principles of Medical Ethics "in addition to *such* disciplinary action as may be taken under the constitution and bylaws of the component society and constituent association to which the Member belongs."

At the June, 1953 meeting of the House of Delegates, the matter of disciplinary service, affiliate and honorary members was considered. The report of the Council on Constitution and Bylaws submitted at this session pointed out the need "for the Judicial Council to have original jurisdiction over members of the American Medical Association who are not members of their component county and constituent state medical societies."

Since service, affiliate and honorary members are not necessarily members of a constituent or component society, the Constitution and Bylaws apparently provided no avenue to discipline these members. Section 2 which was added to Chapter IV of the Bylaws at the June, 1953 meeting provides:

SERVICE, AFFILIATE AND HONORARY MEMBERS.—

The Judicial Council, after due notice and hearing, may censure, suspend or expel any Service, Affiliate or Honorary Member of the Association for an infraction of the Constitution or these Bylaws, or for a violation of the Principles of Medical Ethics.

Chapter XI, Section 10, Sub-section (A) (2) lists the circumstances in which the Judicial Council shall have *original* jurisdiction:

The Council shall have original jurisdiction in (a) all questions involving Membership as provided in Division One, Chapter I, Section 1 of the Bylaws; (b) all controversies arising under this Constitution and Bylaws and under the Principles of Medical Ethics to which the American Medical Association is a party, and (c) controversies between two or more constituent associations or their members; between a constituent association and a component society or societies of another constituent association or associations or their members.

No reference is made in this sub-section to the initiation of original disciplinary action against an active or associate member. On the other hand, it cannot be stated unequivocally that this subsection lists all situations in which the Judicial Council shall have original jurisdiction. Chapter IV, Section 2, of the Bylaws, in clear language, confers original jurisdiction upon the Judicial Council to discipline Service, Affiliate or Honorary members.

The Judicial Council has interpreted its original jurisdiction as follows:

. . . the Judicial Council has no disposition to refuse to accept fully any responsibility that may rightfully be imposed on it under the law of the Association, nor does the Council wish to usurp or to appear to interfere even remotely, with the privileges and duties that are legally and rightfully imposed on the censors and councilors of component and constituent societies. These agencies are charged with specific duties, and it is altogether in keeping with the democratic spirit and purpose of our scheme of organization that they should consider first and adjust all questions of conduct, organization and discipline that primarily concern their individual members of their own units or organization. (Report, 1924: 21-22, Index and Digest of Official Actions of the American Medical Association, page 151.)

The Judicial Council is constantly being asked to deal with matters over which it has no jurisdiction until they have come before the Council of appeal from decisions of the proper official bodies of state medical associations. Original jurisdiction over the acts and professional relations of members lies with the component medical societies and it is the duty of these societies to institute and to carry out any corrective measures that may be indicated. The constituent state association from which the component county society receives its charter has original jurisdiction over the affairs of medical organization in its own state, and its powers and duties are clearly fixed in its constitution and bylaws, to which its own component county societies must subscribe. The Judicial Council cannot institute any action in a county or state having to do with the relations of one member with another, or of a member or groups of members with a state association. If untoward conditions arise in a county it is the duty of the component society of that county to deal with them and this duty cannot be delegated to nor assumed by the Judicial Council. (Report, 1930: 23-24, 37, Index and Digest of Official Actions of the American Medical Association, page 168.)

Sub-section (A) (3), which deals with *appellate* jurisdiction, raises no problems of interpretation in connection with the question under consideration.

Sub-section (A) (4) provides:

The Council shall have jurisdiction on all questions of medical ethics and the interpretation of the Constitution, Bylaws and rules of the Association.

As used in this sub-section "jurisdiction on all questions of medical ethics" undoubtedly refers to the unlimited, *interpretive* authority of the Judicial Council in reference to medical ethics.

Sub-section (A) (5) confers upon the Judicial Council the right to investigate or conduct fact-finding surveys relating to "professional conditions."

Sub-section (A) (6) provides a procedure whereby the Judicial Council may obtain authority to invoke original jurisdiction under extraordinary circumstances:

The Council shall have authority to request the President to appoint investigating juries to which it may refer complaints or evidences of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused.

It appears that under the AMA Constitution and By-laws discipline is largely a local matter reserved to the State and county societies. In practice, the State associations have delegated responsibility for initiating prosecutions of improper conduct to the county societies. It has been suggested that the county society is inadequate to provide effective self-government—that it is as much a close-knit fraternal group as it is a professional organization; that the members of the average local medical community are too interdependent to be able to take drastic action.

In some measure, at least, this suggestion appears to be factual. The results of a survey of county societies, thus far, indicates that instances of official discipline have been few. Assuming that the county societies have not discharged with diligence their responsibility to discipline members, does it necessarily follow that more effective discipline could be achieved by transferring disciplinary functions from the county society to the State association or the AMA?

There are many facets to this perplexing problem which must be recognized before considering remedial action. The local community is ordinarily best able to cope with individuals whose conduct is offensive to the local community. Members of the local community are the first to feel the impact of the improper conduct of their neighbors. Consequently, the motivation to punish offenders should be strongest in the local community.

As lawyers, professionally trained in conducting litigation and prosecution, we are able to appreciate the vexations and frustrations inherent in maintaining professional discipline. Punitive action cannot be instigated solely on the basis of a physician's unsavory reputation among his associates in the community. Democratic standards require adequate proof of charges. Except in isolated cases of extreme notoriety, the gathering of evidence is fraught with obstacles. The circumstances under which medical misconduct occurs are such that even professional investigators, such as government agents, have found it difficult to obtain evidence against physicians. So far as we are informed, none of the county societies employ full time professional investigators as part of their disciplinary activity. Whether conducted by the county society, State association, or even the AMA, the judicial phases of discipline could be no more effective than the investigative techniques employed.

We have considered business as well as other professional organizations in our search for remedial suggestions. Our success in this direction has been very limited. There appears to be substantial evidence, as pointed out in the Waterson statement (page 12), that "the medical profession is *itself* the yardstick."

The American Bar Association is the AMA counterpart for the legal profession, but with considerably less influence over the practice of the individual lawyer. Only a small proportion of lawyers belong to the American Bar Association. Even lawyers who are members of their local bar group do not find it essential to their practice to belong to the ABA. In Illinois (voluntary bar) the Chicago Bar Association is empowered by the Illinois Supreme Court to conduct disciplinary proceedings in the Chicago area and the Illinois Bar Association for the remainder of the State. Recommendations for disbarment or suspensions are made to the Illinois Supreme Court. The recommendations are usually followed. The Illinois and Chicago Bar Associations are independent groups.

Significantly, it appears that the discipline of attorneys usually involves conduct that is not only unethical but *illegal*. Numerically the Chicago Bar Association has been more active in conducting disciplinary proceedings than the Illinois Bar Association. This could be taken as evidence that a local organization is better able to discipline. The conclusion might be reached that lawyers in small communities are more ethical. Lawyers in small communities are generally engaged in general practice as compared to a high degree of specialization in large cities. It could be argued that specialization in the legal profession, as in medicine, might affect ethical conduct. Greater competition for business in large cities may be the prime factor. Or possibly life in a smaller community fosters a closer, more personal

relationship between lawyer and client. Or it might be argued that the statistics have little meaning—that the figures merely indicate greater diligence on the part of the Chicago Bar Association. We have pointed out these possible conclusions for the purpose of demonstrating the need for utter objectivity in making comparisons and utilizing the experience of others.

The Canons of Legal Ethics of the American Bar Association are accepted as standards of conduct for the entire legal profession. In comparing the Canons of Legal Ethics with the Principles of Medical Ethics, the antiquated form of the latter is evident. The Principles of Medical Ethics might be restated in more precise and exacting terms. Decisions of the Judicial Council could be used as a basis for expanding the Principles in their application to particular situations.

Our examination of the rules of the various stock and grain exchanges, and trade associations offers little worthy of comment.

An interesting article dealing with the "Regulations of Physicians by Law," written by a Chicago lawyer, Mr. Harry Eugene Kelly, was published in June, 1924 in the *American Medical Association Bulletin*. Several of Mr. Kelly's statements are still very much in point.

The occupation of healing, on account of the intimacy and importance of its contact with the people, and its effect on the public health, has long been the object of regulation by law very broadly as to the intellectual attainments and moral character of its adherents . . . The legislative regulation of the physician's occupation would probably be unnecessary if every person could accurately determine for himself the physician's ability and character, because, no person being willing to submit the care of his body to ignorant or immoral healers, they could not thrive. But the layman's unaided estimate of a physician is more likely to be wrong than right . . . Determination of a physician's moral character is a task in which persons of the widest experience with men are not so sure of their judgment as to refuse the assistance of those who have made an actual investigation and ascertain the facts about the particular man. (page 183)

. . . the patient's health is not exclusively his own im- providently to dispose of, but is in part the state's and his disease is not only a menace to himself but to his neighbors; so that the kind of treatment which he takes is the business of all of us . . . The good of the whole people is the avowed object of government . . . (page 185)

In all legislative acts passed for regulating the occupation of healing the sick, ample provisions should be made for rendering it impossible to use the profession for committing frauds on the people. There is no part of a legislative act relating to this subject which provides a greater service for the people than that prescribing grounds for the revocation of the licenses of unworthy doctors and for the refusal to grant licenses to unworthy applicants for them . . . The most effective means ought to be put into the hands of public officers for carrying on a vigorous and constant warfare against men who attempt to make villainy a profitable business through the agency of that profession to which all men have learned to look with the hope of receiving fair and efficient treatment for relief from disease, suffering and death. This much the medical profession ought to continue to try to accomplish, because it is a necessary public service, and because it is a necessary public service, and because all persons sincerely desire to support every movement for preventing fraud. (page 187)

Statutes prescribing the requisite regulation of the doctor's occupation will not enforce themselves. Neither are they enforceable by the ordinary public officers charged with general administration of the laws. Special officers must be provided capable of performing the peculiar services required in the administration of such statutes. (page 209)

Those who have the public health in view and want to succeed in this contest will have to make a more vigorous fight. They must organize to educate the people and to inform legislators. They must spend their time and money more freely in presenting the public's cause to the legislatures of the country, and, indeed, to the courts, too, which also require ample arguments on the cases before them. The persistent, the vigilant, the crusading men win. (page 223)

The above quotations are well stated and require little comment. However, they do suggest certain questions. Unethical conduct is a problem of organized medicine, but illegal conduct is the responsibility of government. Have the State licensure boards received the maximum of cooperation and assistance from organized medicine? Have the best men been selected to those boards? Is organized medicine vigilant in securing statutory

enactment of medical standards of ethics? Are existing facilities fully utilized in obtaining compliance and discipline?

Organized medicine has long recognized that government has a proper role in licensure. Effective licensure benefits the public and the profession. Licensure laws of the various states establish standards not only for admittance but for practice. Organized medicine assumed the leadership in the enactment of licensure statutes, but has organized medicine pursued with the same zeal the enforcement of these statutes in respect to practicing physicians?

As we have pointed out elsewhere the investigation and prosecution of misconduct requires the assistance of adequately trained personnel. It may be possible that a program could be developed whereby the State associations directly assist the county societies and licensure boards in disciplinary actions. A uniform national policy and program might produce the desired results.

Public officials charged with law enforcement generally attach far greater significance to prevention than to punishment. It may be that a thorough overhauling of the economics of medicine is necessary. As the Waterson statement points out (page 4) "perhaps disparity between medical and surgical fees" is a reason for unethical practices. Or it may be that erroneous attitudes held by the public as to the comparative value of the various services performed by medicine and surgery tend to act as a corrupting influence upon physicians and surgeons.

An intensive educational program may be necessary to maintain (or possibly restore) the full confidence of the public in the medical profession. The public may need to be educated as to what it is entitled to expect from the medical profession; in respect to both services and charges. Modern medicine may be too much of a mystery to the layman. An informed public, able to recognize the corrupt and irresponsible physician, would reward the ethical physician with its confidence.

It may be that the medical schools are merely introducing students to the Principles of Medical Ethics and are not devoting sufficient time to molding professional character. Students of medicine anticipate financial benefits among other rewards for learning, but there are obviously easier roads to ill-gotten gain than years of study in medical school and internship. If young doctors are being corrupted in practice, it may be because the schools have failed to provide adequate ethical education or because organized medicine has failed to stress ethics and provide an economic climate which rewards ethical practice.

In an address delivered in 1934 at the University of Michigan, Justice Harlan F. Stone made certain remarks about the role of the law school which might apply with equal force to the medical school:

From the beginning the law schools have steadily raised their intellectual standards. It is not too much to say that they have worshipped the proficiency which they have sought and attained to a remarkable degree. But there is a grave danger to the public if this proficiency be directed wholly to private ends without thought of social consequences, and we may well pause to consider whether the professional school has done well to neglect so completely the inculcation of some knowledge of the social responsibility which rests upon a public profession . . . I have no thought that men are made moral by the mere formulation of rules of conduct, no matter how solemnly bar associations may pronounce them, or that they may be made good by mere exhortation. But men serve causes because of their devotion to them. The zeal of the student for proficiency in the

law, like that of his elder brother at the Bar, comes from a higher source than selfishness. It is devotion to his conception of a useful and worthy institution . . . It is not beyond the power of institutions which have so successfully mastered the art of penetrating all the intricacies of legal doctrine to impart a truer understanding of the functions of those who are to be its servants. (Albert J. Harno, *Legal Education in the United States*, page 159; also 48 *Harvard Law Review* 1).

Do all medical schools require courses in medical ethics? Are the courses now offered adequate? Is organized medicine stressing ethical conduct by conducting "clinics" in medical ethics for practicing physicians?

In conclusion, we would like to make this observation. Anglo-Saxon law, considered the world's best, has developed through evolution. All efforts should be first directed toward making the existing system more effective before controversial changes are attempted. In line with a program of assistance to the state and county societies we recognize the need for clarification of the sections of the Constitution and Bylaws which pertain to discipline, and revision and amplification of the Principles of Medical Ethics in more precise language.

—AMA Legal Department

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By discussions with practicing physicians, hospital administrators, and professional hospital inspectors, we have found it is taken for granted that the hospital is the only realistic approach to supervision of doctors. When questioned, these people point out (1) that it is only in the hospital that there are systematic records, including pathologists' reports; (2) that the threat of losing hospital privileges makes the doctor willing to submit to professional discipline; (3) that the public's support of the accreditation program enhances the hospital's strength as a disciplinary unit.

It seems to us that something of professional unity and dignity is lost with the uncritical acceptance of this reasoning as the *total* answer to the problem. Furthermore, from the point of view of the public interest, it would seem that reliance on hospitals, one by one, for the maintenance of standards could well accomplish merely a division of the community's hospitals into two classes: hospitals staffed by conscientious men and hospitals for mavericks.

It might be that the profession would find the matter of self-discipline less vexing if some differentiation could be established between judgments of competence and judgments of ethics. It is logical that the hospital be the setting for evaluating a man's competence in his work. Ideally, the hospital should provide the teaching environment in which a doctor could grow and learn from other doctors. Once the question of competence is evaluated, however, there still remains the possibility that a man is not honest. If he is a crook, in the considered judgment of his peers, he should be dealt with in some more conclusive fashion than the mere rescinding of his privileges in one hospital. He should be removed from the company of ethical physicians and deprived of their tacit endorsement.

We conclude from these studies that the present supervision of organized medicine over the ethical standards of doctors is not adequate to protect the public, or the good name of the profession. We wish to call this forcefully to the attention of the Board of Trustees and therefore,

2. more precise differentiation between ethics and professional etiquette;

3. and an investigation of the possibility for further cooperation between the state associations and the state licensing boards on the supervision of medical practice, and any other procedures which might be used by state associations for the protection of the public.

In making these recommendations, we are aware that the Judicial Council and the Council on Constitution and Bylaws are concerned about these questions. We wish only to suggest that our investigations emphasize the urgency of re-establishing medicine's position as a self-disciplining group.

WE RECOMMEND:

That the Board direct the appropriate councils or committees to make a thorough study of the procedures which might be used to protect the public from unethical practices, including:

1. a definition of where the responsibility for the maintenance of ethical standards does lie;

WE FURTHER RECOMMEND:

That when this study is accomplished and its conclusions implemented the public be informed exactly where the responsibility does lie and what procedures are established for their protection; and that this clearer delineation be used to offset adverse reactions against the AMA and the profession in general.

60 YEARS OF X-RAY

RADIOLOGY CELEBRATES ITS 60th Anniversary this month. On November 8, 1895, Wilhelm Conrad Roentgen, a professor of physics at the University of Wurzburg in Germany, discovered this new kind of ray.

The story is fascinating; the discovery was no accident, but was rather the climax to a series of experiments that he (and other European scientists) had been carrying on with cathode rays. It was known that the invisible cathode rays produced a fluorescent effect on a cardboard painted with barium platinocyanide, but only when this screen was placed fairly close to the window of a cathode ray tube equipped with a thin aluminum window.

The actual discovery is described by Dr. Otto Glasser in his book, *Dr. W. C. Roentgen*: "Late one afternoon when, as was his custom and preference, he (Roentgen) was working alone in the laboratory, he determined to test the ability of a Hittorf-Crookes tube, that is, an all glass tube without a thin window, to produce fluorescence on the barium platinocyanide screen. Selecting a pear-shaped tube from the rack, he covered it with pieces of black cardboard, carefully cut and pasted together to make a jacket similar to the one used previously on the Lenard tube, and then hooked the tube onto the electrodes of the Ruhmkorff coil. After darkening the room in order to test the opacity of the black paper cover, he started the induction coil and passed a high tension discharge through the tube. To his satisfaction no light penetrated the cardboard cover.

"He was prepared to interrupt the current to set up the screen for the crucial experiment when suddenly, about a yard from the tube, he saw a weak light that shimmered on a little bench he knew was located nearby. It was as though a ray of light or a faint spark from the induction coil had been reflected by a mirror. Not believing this possible, he passed another series of discharges through the tube, and again the same fluorescence appeared, this time looking like faint green clouds moving in unison with the fluctuating discharges of the coil. Greatly excited, Roentgen lit a match and to his great surprise discovered that the source of the mysterious light was the little barium platinocyanide screen lying on the bench. He repeated the experiment again and again, each time moving the little screen farther away from the tube and each time getting the same result. There seemed to be only one explanation for the phenom-

non. Evidently something emanated from the Hittorf-Crookes tube that produced an effect upon the fluorescent screen at a much greater distance than he had ever observed in his cathode ray experiments, even when he had used Lenard tubes with the thin aluminum windows.

"Realizing that this conclusion was certainly in contradiction to general knowledge about cathode rays and especially his own experience that cathode rays never penetrated more than a few centimeters of air, he became deeply absorbed in attempting to explain the strange phenomenon."

So thorough and accurate was this initial investigation by Doctor Roentgen, that little has been added to the fundamental knowledge he reported in his first paper in late December 1895—"On a New Kind of Rays, Preliminary Communication."

Dr. Roentgen's study of his wife's hand—the first x-ray plate ever made—interested scientists throughout the world. Medical men quickly perceived the importance of being able to see "inexcessible body parts" and hailed the discovery as a great benefactor to mankind.

During the early years, the science of roentgenology progressed as techniques and materials improved. Contrast media made possible the exploration of the gastrointestinal tract, the urinary tract, the gallbladder and other organs. More powerful x-ray tubes, perfected by such men as W. D. Coolidge, shortened exposure times and sharpened the images on films. Therapy machines became more powerful, producing x-rays of exceedingly short wave length, capable of greater penetration and greater tumor dosages with relatively less harm to the overlying skin and normal tissues.

The continued progress in the field of radiology is well shown by the following developments of the last two decades: angiocardiology, cerebral arteriography, and aortography; myelography with iodized oil; intravenous cholangiography; electronic amplification of the fluoroscopic image; photoroentgen timing; mechanical processing of films; rotational therapy; and the wide-spread use of isotopes, such as radioactive cobalt, in diagnosis and therapy.

The future of radiology appears bright. Before long, there will be x-ray tubes available capable of exceedingly short exposures; there will be units which will turn out a completely processed and dried film in a matter of a few minutes; there will be continued improvement in the development of contrast media.

Radiology has sought to improve the caliber of

its personnel in keeping with its improvements otherwise. Educational requirements in the fields of diagnosis, therapy, and technique are being constantly heightened.

The radiologist and the technical personnel are proud to be members of the medical team fighting the constant battle against disease.

THE PSYCHE AND THE SOMA

AMONG PHYSICIANS throughout the country there is a growing concern over recent rises in malpractice insurance rates. This rise in malpractice insurance rates has especially affected the various specialty groups. There has been extensive comment recently in medical and hospital journals as well as the public press regarding this trend. Various explanations have been offered.

A combination of his time and skill is what the physician has to offer to his patients. A proper combination of these makes him of the greatest usefulness to those who seek his services. The average physician whether he be a specialist or a general practitioner spends much time reading medical journals, attending hospital staff meetings, and taking refresher courses from time to time in an effort to keep abreast of the progress of medical science. In addition to the time necessary to handle his practice and keep up with the progress of his profession, he also has demands upon his time from his family and his civic duties. All of these factors sometimes conspire together in such a way that the physician may seem hurried in handling his patients, and he may overlook the fact that the patient has emotional needs as well as physical ills.

It is by no means uncommon for intelligent patients to leave a physician's office with a feeling of frustration and even of resentment. There may be matters that the patient wanted to discuss with the physician regarding his condition, but the assembly line methods of taking patients through the mill of the office or of making hospital rounds discourages the patient from asking questions that to him seem important.

The patient who presents himself to a physician does so because of concern or anxiety. He has symptoms which he suspects are caused by something, but the cause and remedy are beyond his knowledge and capacity. This makes him anxious to seek help whether his chief complaint is a pain, a new growth, or some other annoying condition. Beyond it all lies anxiety. From the standpoint of the patient there

is something wrong and the distress to him is real, although the physician may not find physical evidence to explain the symptoms. The patient and the disease both must be treated.

How much this feeling of frustration and dissatisfaction is a factor in the increase of malpractice suits because physicians fail to recognize the emotional needs of patients is a matter of speculation. It seems desirable to reiterate the oft repeated admonition of viewing the patient as a whole and to be aware of the emotional needs of the patient as well as the symptoms or condition for which he seeks treatment.

REPORT ON MEDICAL PRACTICE

THOROUGH KNOWLEDGE and complete understanding prevents misrepresentation and misinterpretation of any subject. To understand and to be able to discuss a subject intelligently, one must be familiar with the question from all sides. The question of unethical practice in the medical profession has been debated for a long time without facts and figures to aid arriving at any conclusion.

A special Committee on Medical Practice was appointed by the A.M.A. "to study the basic cause of fee splitting and other unethical practices that have been the subject of adverse publicity for the medical profession." This committee has presented the facts on this subject in a thorough manner; without deleting any data which might be used to mislead the public by those who wish to deride the medical profession.

For some unexplainable reason this report (which is reprinted in full beginning on page 530 of this issue) was withheld from the medical profession for sometime, and many so called reports and articles appeared in magazines purporting to be excerpts from this committee's findings. Since this report was of the medical profession and for their edification, it should have been given to them first. At last the physicians have the full report. It should be studied thoroughly and proper action taken.

This report contains over fifteen thousand words with many direct quotations and comments from physicians, teachers, and patients giving a clear knowledge of the facts in question. Many favorable comments have appeared as to the thoroughness and fact finding ability of the committee. They have done a good job, they have presented the data as they found it, and much good can come from it's study.

The conclusions and the recommendations of this committee are before us. Let us study them and then take action to remedy any "ills" that are found in each and every community.

PULMONARY NODULES

ALL STUDIES TO DATE have been based on nodules that have been resected. Several recent series are illustrative of this, namely that of Mood, et al,¹ who in their study of 156 cases in which resection was performed at the Mayo Clinic found approximately 35 per cent of the lesions to be malignant and the remaining 65 per cent benign. Jones and Cleave² reported on a collected series of 714 pulmonary coin lesions in which they found 35 per cent malignant tumors, 40 per cent inflammatory lesions, 12½ per cent benign tumors, and the remaining 12½ per cent to be a heterogenous group of lesions. Storey, et al,³ reported on 40 consecutive patients with coin lesions, histologically studied, and found 17.5 per cent of these to be cancer, 70 per cent to be classed as "tuberculomas," and approximately 10 per cent of the tuberculomas actually proved to be blocked tuberculous cavities.

The recent trend in management of such pulmonary infiltrates has been to excise them as soon as possible, on the presumption that they were either early bronchogenic carcinomas or unstable inflammatory lesions. There is need for more objective data that might spare selected patients such an operation. In the series reported by Hood, Good, Clagett and MacDonald,¹ every lesion in which calcification could be demonstrated proved to be benign. Lamina-graphy was frequently necessary to visualize this calcification. In addition, although most of the lesions were peripheral and therefore unfavorably situated for the recovery of exfoliative cells, the diagnosis by cytological examination of the sputum was made in 53 per cent of the cases of bronchogenic carcinoma. Bronchoscopy and other diagnostic efforts were non-contributory in almost all of the series of studies reviewed. On the other hand, for those coin lesions in their experience in which calcium could not be demonstrated they recommended prompt surgical excision. They also found that the sedimentation rate was frequently elevated in patients with malignant lesions, but usually not in those with benign nodules. The tuberculin test, when negative, increased the suspicion of neoplasm also.

Rigler,⁴ in a recent publication, has emphasized that the irregularity of the nodule as seen on the X-ray film (scalloping of the borders) to him always means a malignant neoplasm. Sanger⁵ of Charlotte, North Carolina, has had recent experience with several cases in which there was calcium noted on the

X-ray film and at thoracotomy a carcinoma removed. In addition, London and Winter⁶ have recently reported a case in whom a pulmonary nodule containing calcium proved to be a slow-growing well differentiated adenocarcinoma. However, these latter are isolated cases.

We⁷ are in the process of reviewing a series of 88 cases of pulmonary nodules, the medium rate of follow up being 48 months representing the first X-ray film to the last X-ray study, and 53 months representing the interval between the first examination and the last information on the patient. In our experience all the carcinomas proved to be in white males over 30 years of age, and in those 33 patients who demonstrated calcification and/or lamination to date no carcinoma or tuberculosis has been proved. These latter patients have not been operated on. Ten of these cases who demonstrated increase in the size of the nodules died of cancer or pulmonary tuberculosis. In those cases in which the initial measurement proved to be 28 mms and over, three of nine proved to be cancer, three of nine proved to have pulmonary tuberculosis. Of all of those cases under 28 mms, one out of 79 proved to have cancer and two out of 79 proved to have tuberculosis.

All patients who have pulmonary nodules should be individualized in their respective management. It would seem reasonable to handle those small round pulmonary nodules which contain calcification and/or lamination in a conservative manner. And certainly, the lesion containing no calcium, having irregular contours, over 28 mms in size, and in the patient who has a negative tuberculin test and an elevated sedimentation rate should be resected. Obviously, not all of the latter conditions need obtain to warrant thoracotomy; however, there should be a sufficient number of them to justify surgery. All that is nodular in the chest is not necessarily cancer or an unstable tuberculous focus, and careful consideration of all aspects of the case should be carried out before recommending operation.

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Enlarged Glands

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AN ENLARGED GLAND in the neck, axilla, or groin is frequently the symptom which first brings a patient to the doctor. Of course a great majority of such enlarged glands, especially in children, are caused by either acute or chronic inflammation with some obvious and simple explanation. This is particularly true of cervical glands whose enlargement is so often caused by infections in the nose, throat, teeth, ears, and skin of the face or scalp. Some of these glands become chronic or fibrosed and remain so for months or even years after the original infection is forgotten. Such glands usually are not tender and present a real diagnostic problem in that they may be confused with Hodgkin's Disease or some other malignant tumor, and the mistake not discovered until the disease manifests itself elsewhere. When in doubt, the enlarged gland should be excised for pathological examination. A blood count will disclose leukemia if present. One should not assume that a chronically enlarged gland is inflammatory without careful study.

Enlarged axillary glands, without an obvious source of acute inflammation on the hand or arm, are much less frequent than similar cervical glands, always demand immediate serious consideration and usually immediate excision or biopsy. Occasionally people whose occupations cause frequent minor infections of the hands such as butchers, mechanics, etc., will develop small, hard, chronically infected, painless glands in the axilla but this is unusual. Fairly often Hodgkin's Disease, the other lymphomas, and even carcinoma of the breast first manifest themselves by an enlarged axillary gland. Occasionally the original tumor in the breast is so small that it cannot be found by even the most careful examination after typical breast cancer has been found by pathological examination of an axillary gland. Of course a radical mastectomy is mandatory even though the primary tumor is not palpable. When an enlarged gland is found in both the neck and the axilla, lymphoma or metastatic carcinoma will be found in almost every case.

A few small firm chronically inflamed or fibrosed glands are a very common finding in both groins. Usually these glands are less than 0.5 centimeter in size, and the presence of a solitary gland much larger

than all the others should arouse immediate suspicion and diagnostic study. The groin is the least likely place for primary manifestation of lymphomas, and as a rule other glands, in axillae or neck, are enlarged also. Metastasis to inguinal or femoral glands most often originates in the genitalia but may come from an unnoticed small melanoma on the foot or leg.

Occasionally iliac glands are enlarged when the inguinal glands are normal. These cannot be felt until they are fairly large, but when found they may be of great diagnostic significance. A thorough search for a primary tumor in the pelvis and for lymphoma is indicated. Examination for iliac nodes should be made by standing opposite the patient's thigh and facing the patient. The tips of examining fingers are then rolled over Poupart's ligament with downward pressure. The normal smooth muscular shelf and large vessels are identified in this way. The shelf should be the same width on both sides. If the shelf is noticeably wider on one side, and certainly if it is nodular, one may assume that the iliac glands are enlarged.

Except in very thin subjects, abdominal and mesenteric nodes cannot be felt until they attain very large size, and by then the disease is usually obvious and far advanced.

Of all accessible areas, axillary glands are probably most often overlooked and, when enlarged, they are of greatest diagnostic significance. They cannot be found by examination through clothing or by running the hand under the patient's shirt or by making a half-hearted pass along the edge of the pectoralis muscle.

The examiner should be seated in front of the patient and be on the same level; he should support the patient's right elbow with his left hand. The tips of the examiner's right fingers are then used to examine the patient's right axilla. The most important thing is to get "rag doll" relaxation of the patient's entire arm. This is frequently difficult to obtain. Next, the doctor should lift the relaxed arm to a horizontal position and pass the tips of his fingers as high as possible into the apex of the axilla. Then pressure should be made against the chest wall and maintained as the fingers and skin are slipped down-

ward. The elbow is lowered at the same time that the examining fingers are passing downward over the chest wall. If any enlarged glands are present they will be felt to "jump" as the fingers pass over them. Occasionally a firm pad of fat in a stout patient will produce a similar reaction and must be carefully evaluated.

Whenever enlarged glands are found anywhere, careful examination of the spleen and a thorough blood study must be made.

A careful search for enlarged lymph nodes will clear up many diagnostic puzzles and disclose many unsuspected malignant diseases. Look for them, and, when you find enlarged glands, do not hesitate to excise one for pathological study!

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The Diagnosis of Ventricular Septal Defect

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ISOLATED VENTRICULAR septal defect is one of the commonest forms of congenital heart disease. It is indeed more common than was formerly thought, for it occupies an increasingly high percentage in clinical reports dealing with the diagnosis and treatment of congenital heart disease. Like many other diseases now more thoroughly studied, this does not reflect an increase in incidence, but rather clinical recognition of many types of the illness not previously diagnosed. In the past five years much has been learned of this lesion from many laboratories of the world.

Most standard textbooks treat isolated ventricular septal defect as a rather benign lesion, characterized by a loud murmur accompanied by no other significant findings. This mild type of the lesion is often named *maladie de Roget*, and it is too often thought that this rather insignificant clinical entity characterizes the ventricular septal defect. It is now known that only about one-third of the cases scientifically diagnosed exhibit this mild type of lesion; in two-thirds of the cases the structural defect is large enough to deform the heart and produce symptoms indicative of an embarrassed circulation. Therefore, in most instances this lesion does not deserve the innocent prognosis that custom has assigned it.

The size of the opening between the ventricles determines, more than the precise anatomic location, the extent to which the heart will be embarrassed by escape of blood from one chamber to another. The load which each ventricle will assume is related to the magnitude of the shunt and the presence or absence of hypertension in the pulmonary circuit. If the defect be large enough the economy of both ventricles is disturbed: the left, by the fact that there is a double outlet for its output; the right, by the fact that an increased amount of blood is added to the pulmonary circulation.

The amount of blood that traverses the pulmonary

circuit is greatly influenced by the pulmonary arterio-
lar resistance. In most cases there is a brisk left to right shunt; if the pressure in the pulmonary circulation, however, is equal or almost equal to that of the systemic circulation, a mixed shunt or a temporary right to left shunt may occur. It is thus possible to recognize three groups of ventricular septal defect on the basis of right ventricular pressure: (1) normal systolic pressure; (2) elevated systolic pressure, but less than systemic; (3) systolic pressure equal in both ventricles. These three types may often be recognized on fluoroscopic examination of the heart.

On fluoroscopic examination most cases of isolated ventricular septal defect will show an increased pulmonary flow manifested by dilatation and pulsation of the pulmonary artery and its branches. This appearance is pathognomonic of the left to right shunt; and when the shunt is slight, this sign may not occur, and the roentgen appearance of the heart will be normal. When the flow is large and the right ventricular pressure is raised, there is evidence of cardiac hypertrophy in both ventricles, and often in the left atrium. In most instances the enlargement of the right ventricle outstrips the left. When the pressure in the two circulations is equal, the roentgenographic examination is the same except that the peripheral vessels of the lung are often narrow, suggesting a diminished left to right shunt.

Because the heart may have the same appearance in auricular septal defect and in some cases of patent ductus arteriosus, careful cardiac catheterization is necessary to establish the diagnosis. Blood gas analysis of venous blood from the right heart will show a contamination with arterial blood at the level of the right ventricle, and the diagnosis can be made with reasonable certainty. Surgical correction of patent ductus arteriosus and auricular septal defect is established, and correction of ventricular septal defect is now feasible and, in a few years, may be perfected.

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.

doctor placement page



NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

AVAILABLE PHYSICIANS

Anthony, James E., Jr., M.D., Presbyterian Hospital, 1753 West Congress St., Chicago 12, Illinois—Age 32; married; Methodist; graduate University of Maryland, 1947; residency Jefferson Hospital, Roanoke, Va.; Emory University Hospital, Atlanta; Presbyterian Hospital, Chicago, Ill.; specialty surgery; available June 1957.

Archibald, Donald Harper, M.D., 15 McElaney Drive, Black Pt. Road, Niantic, Connecticut—Age 55; married; Presbyterian; graduate Dalhousie University, Halifax, N. S., 1936; residency (Pathology) St. Vincent's Hospital, New York City, two years; Assistant Surgeon, St. Anne's DVA Hospital, Montreal, 2½ years; available now.

Bennett, Claude E., Box 85, Letterman Army Hospital, San Francisco, California—Age 36; married; graduate Medical College of Alabama, 1952; residency Letterman Army Hospital, in Pediatrics; member AOA, AAGP and AMA; interested in general practice with pediatrics; would consider partnership or group association; prefers to practice in Georgia or Alabama; available September 1956.

Black, John J., 763 Paulsen M & D Bldg., Spokane 1, Washington—Age 47; married; Catholic; graduate St. Louis University School of Medicine; American Board of Ob-Gyn; presently in practice in Ob-Gyn; wishes to relocate due to seasonal sensitivity; private practice, assistant, associate or clinic; available within 30-60 days after location is secured.

Calkins, Robert S., M.D., 8983 Mission Boulevard, Riverside, Calif.—Age 36; married; Presbyterian; graduate Oklahoma University, 1947; residency Presbyterian Hospital, Philadelphia, Pa.; specialty O. B. Gyn; available now.

Clifford, William S., 1509 Fourth Avenue, Columbus, Georgia—Age 44; married; Presbyterian; graduate Medical College of Virginia, 1943; residency Univ. of Michigan Hospital; Certified 1952 Ob-Gyn; interested in Gyn-Ob; association with private certified Ob-Gyn; available immediately.

Damron, John R., M.D., 216 Pearl St., Jackson, Ohio—Age 30; married; two children; Methodist; graduate University of Louisville, 1952; residency intern St. Vincent's Hospital, Toledo, Ohio. Interested in general practice in community of 8,000 or larger. Available now.

Donovan, Raymond Joseph, 60-05 East 194 Street, Fresh Meadows 65, New York—Age 30; married; Roman Catholic; graduate Cornell University Medical College, 1952; residency St. Clare's Hospital, New York; Priority IV; specialty Ob-Gyn; clinic, assistant or associate; available July 1956.

Hagler, William S., 5201 Harry Hines Blvd., Dallas 19, Texas—Age 25; single; graduate Medical College of Georgia, 1955; interested in General Practice; preferably group practice; draft exempt; serving rotating internship at Parkland Memorial Hospital, Dallas, Texas.

Hall, Donald Lurve, 3221 W. Main Street, Kalamazoo, Michigan—Age 26; married; Episcopalian; graduate New York Medical College, 1955; interested in general practice, assistant or associate; available July 1956.

Hughes, Robert Rule, M.D., 18th Tac Hospital, APO 239, San Francisco, Calif.—Age 27; single, graduate University of Tennessee, 1952; will be released from service and desires 2-3 years work prior to residency; available May or June, 1956.

King, Donald Perry, 932 East 56th Street, Chicago 37, Illinois—Age 33; married; Protestant; graduate George Washington University Medical School, 1946; residency Western Reserve University Hospital; American Board of Radiology; presently in practice as Asst. Prof. of Radiology; wishes to relocate to go into

practice; specialty radiology; available January-July 1956.

Marks, Charles Henry, Thayer VA Hospital; Nashville, Tennessee—Age 28; married; Jewish; graduate Vanderbilt University School of Medicine, 1951; residency VA Hospital, Nashville, Tenn.; on July 1, 1956 will be Board certified in general surgery; Priority IV; specialty general surgery; available July 1, 1956.

Mason, Roscoe E., M.D., Surgical Service U. S. Army Hospital, Fort Bragg, North Carolina—Age 32; married; Methodist, graduate Harvard Medical School, 1948; residency Boston City Hospital 13 months remainder including chief residency at Tripler General Hospital (U. S. Army) Oahu, T. H.; expect to be discharged August 1, 1955; available 1-15 August, 1955.

McRee, Jean Douglas, Box 508, Norwich, Connecticut—Age 32; married; Presbyterian; graduate University of Tennessee School of Medicine, 1946; residency Emory University Hospital, Grady Hospital and Norwich State Hospital; holds Georgia license; 3 years approved psychiatric training; formerly practiced in Unadilla, Ga.; Category IV; interested in psychiatry in clinic or as an assistant or associate; available January 1956.

Payne, Woodrow, M.D., 764 McConnell, Memphis, Tenn.—Age 34; married; Protestant; graduate University of Tennessee, 1944; 2½ years practice in urology. Primary interest in individual practice in city of 20,000 to 75,000 population; will consider group, purchasing an established practice, or partnership in aforementioned size city.

Reese, Howard Lanier, 3422 Walnut Street, Philadelphia 4, Pennsylvania—Age 33; married; 3 children; graduate University of Pennsylvania School of Medicine, 1948; residency Hospital of the University of Pennsylvania 1949-54; Certified American Board of Surgery, 1954; interested in general surgery; would consider clinic, assistant or associate; available September 1, 1956.

Yingling, Nathaniel D., M.D., Thayer Veterans Hospital, White Bridge Road, Nashville 5, Tenn.—Age 32; married; Methodist; graduate Jefferson Medical College, Philadelphia, Pa., 1947; residency three years preceptorship at Clearfield Hospital, Clearfield, Pa.; two years approved by American Board of Surgery. Will complete Board requirements at Thayer V. A. Hospital residency July 1, 1956. Available August 16, 1955.

AVAILABLE LOCATIONS

Arlington, Georgia (Calhoun County)—Population 1,382. In need of doctor-surgeon for practice in new excellently equipped 16-bed hospital, located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia.

Atlanta, Georgia (Fulton County).—Needed immediately, young man doing general medicine interested in association with established X-Ray and clinical laboratories. Contact: Drs. Landham & Klugh, 736 Piedmont Avenue, N.E., Atlanta, Georgia.

Braseltton, Georgia—(Jackson County)—Doctor must now come from one of following places: Jefferson, 10 miles; Winder, 10 miles; Lawrenceville, 20 miles; Gainesville, 20 miles; Buford, 20 miles. Have a well equipped clinic and a home rent free. Clinic is rent free and home until doctor can afford to pay rent or buy a home. Possible that home will be furnished free.

Broxton, Georgia (Coffee County)—Population 3,500—Doctors clinic available; also home available; 60 room county hospital at Douglas; seven room doctors building; no physician in area; physician will have more work than he can do. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia.

Dillard, Georgia (Rabun County)—Popu-

lation 2,500. Doctor's office to be furnished rent free for one year; would rent five or six room house, fully equipped kitchen, county hospital at Clayton; drug store and pharmacist; good schools; doctor would be welcome right now; late doctor had an excellent practice; other benefits considered in a short time; active church groups and community club that would be happy to assist doctor. Contact: Mrs. L. Neville, Dillard, Georgia.

Grantville, Georgia—Coweta County—Population 1500; in a radius of six miles no physician; there is also a large country practice; hospital facilities in Newnan, Georgia, 10 miles from here; available office space, modern drug store next door. Excellent schools; 2 excellent churches, Methodist and Baptist; swimming pool, tennis, picnic grounds available. Full-time physician needed. Contact Mr. B. D. Banks, Grantville, Georgia.

Hampton, Georgia (Henry County)—Population 1,000—No doctor in Hampton, nearest 10 miles away; hospital in Griffin; office space, housing available; contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia.

Hartford, Connecticut—Connecticut General Life Insurance Company. Full-time proposition; candidate should be under 40, graduate of grade A American or Canadian Medical School; with preferably one-two years internship or residency; must have served full time in military service; starting salary \$8,000-\$10,000 dependent on age and experience; excellent opportunity for advancement; five day, 40 hour week; liberal disability and life insurance coverage, paid vacations; exceptional pension and incentive plan. If interested communicate with N. J. Barker by letter marked personal and confidential; if we are interested would defray expenses to Hartford for an interview; Contact Norman J. Barker, M.D., Medical Director.

Jeffersonville, Georgia (Twiggs County).—One physician in area doing limited practice; hospital facilities nearby in Macon; office space available with small rental or purchase; one drug store with registered pharmacist; house made available immediately; 69 lakes stocked with bass, brim or trout; 150,000 acres woodland makes Twiggs County good hunting ground for small game; definite need for physician. Contact: Mr. H. C. Swearingen, Jeffersonville, Georgia.

Smithville, Georgia (Lee County)—Population 700—No physician in area; home in Leesburg, office downtown rent free; completely equipped office of two rooms and connecting lavatory with outlets for sterilizers, etc., attached. All Contact: Mr. E. H. Conner, Unadilla, Georgia.

Snellville, Georgia (Gwinnett County).—Population 500, area 5,000. No physicians in area; hospital facilities in surrounding area, Atlanta, Stone Mountain, Buford, and Duluth; new office and home, stone building; new \$216,000.00 high school started in September 1955; new Baptist and Methodist Church buildings. Contact: Mr. Ralph Head, Snellville, Georgia.

Unadilla, Georgia (Dooly County)—Population 1,200—Dooly County Hospital owned and operated by the people of the county; office space available or will build small clinic and let doctor rent or buy. Housing will be provided rent reasonable or can get house built to suit. They guarantee a good doctor will do well; one physician in area, age 75.

Woodbine, Georgia (Camden County).—Population 1,000. Small, fully equipped office and clinic available; ample office space, delivery room, laboratory (inc. x-ray), nursery, wards, private rooms; five room wooden dwelling adjoins hospital available at \$35.00 mo.; one other doctor in Woodbine, doctor is needed now. Contact: Dr. S. C. Atkinson, Waverley, Ga.



abstracts by georgia authors

Manchester, P. Thomas, Jr., Jose Bonmati, Ted F. Leigh, and F. Phinizz Calhoun, Jr., 478 Peachtree St., N.E., Atlanta, Ga. "Experimental Orbitography," *Am. J. Roentgenol. Radium Therapy & Nuc. Med.* 74:508-517 (Sept.) 1955.

Because of the difficulties associated with diagnosing orbital tumors, animal experiments were performed to determine the possible usefulness of injecting Diodrast directly into the orbital tissues. In rabbits and in humans, the dye dissected along tissue plane and clearly delineated the eye, the optic nerve, and the extra-ocular muscles. Artificial tumors produced by deposits of latex could be easily localized by the technique of Diodrast injections. In some instances, 35 per cent Diodrast produced histologically demonstrable foci of scleral necrosis, and therefore it was decided that the method would probably have a limited usefulness with clinical cases.

Bell, Hugh V., and Abner Golden, Emory University, Ga. "Castration Changes in the Pituitary with Seminiferous Tubule Atrophy," *Arch. Path.* 60:117-121 (Aug.) 1955.

Findings characteristic of castration are described in the adeno-hypophysis of a patient with seminiferous tubule atrophy and Leydig cell hyperplasia. These changes consist of a marked increase in basophil cells and the presence of many swollen chromophobes with basophilic cytoplasmic stippling. Some vacuolization of the basophils was present but was not marked. It is generally accepted that in the testis the Leydig cells elaborate androgen, and the majority of observers consider that the Sertoli cells of the seminiferous tubules produce estrogen. When there is increased production of follicle stimulating hormone (castration, Klinefelter's syndrome) the administration of androgen, unless in very high dosage, does not alter the production of FSH, but estrogen administration, even in small doses results rapidly in decreased output of this gonadotrophin. Castration changes in the anterior pituitary would appear to result from a loss of estrogen secretion by the testis and to be a reflection of markedly increased gonadotrophin production in this organ. The finding of extensive castration changes in a patient with loss of tubules, but normal or hyperplastic Leydig cells, points to the seminiferous tubules as the site of estrogen formation.

Torpin, Richard, Medical College of Georgia, Augusta, Ga. "Placenta Circum Vallata and Placenta Marginata," *Obst. & Gynec.* 6:277-282 (Sept.) 1955.

Two hundred word abstract quite impractical. The gist however is that there is evidence presented that placenta marginata (36 per cent of all human pregnancies with discoid placenta) and placenta circumvallata (one to five per cent of all human pregnancies with discoid placenta) are due to too extensive area of early placentation based hypothetically on excessively deep implantation of the ovum into the decidua. When the original placenta covers more than the normal $\frac{1}{4}$ and up to $\frac{1}{2}$ of the fetal sac marginata results from gradual reduction in size with atrophy of the villi around the margin. When the area is more than $\frac{1}{2}$ up to $\frac{3}{4}$ of the early sac the growing contents bulge the membrane area and pass through the resulting placental ring which is pulled back onto the face of the placenta to form circumvallata. It is the author's conviction that most spontaneous abortions and premature placental separations are the inevitable results of these factors resulting from marginal decidual hemorrhage as the excess placenta is detached from the uterine wall. Three other hypothetical variations in depth of implantation originate; (a) infrequent double discoid placenta (monkey type), (b) normal placenta 60 per cent, and (c) the rare membranacea. There is reported a case of extreme degree of circumvallation carried successfully to term.

Hamilton, Clara E. and Francis J. Smiley, Dept. of Zoology, University of Georgia, Athens, Ga. "Development of Alloxan Diabetes in the Albino Rat," *Am. J. Physiol.* 181:493-497 (June) 1955.

Since it has been a matter of controversy what part of the adrenal has to play in the developing alloxan diabetes, an investigation of adrenal cortical changes, blood electrolytes, and organ weight changes were made during the development of alloxan diabetes of varying severities in albino male rats of the

Wistar strain. Our results showed slight blood electrolyte fluctuations, slight decreases in lymphatic organ weights, kidney hypertrophy, no changes in other organ weights, no alteration in leucocyte counts, no adrenal hypertrophy, a decreased adrenal ascorbic acid content, and altered adrenal osmophilia. Therefore, it is our conclusion that in the rat the symptoms of developing alloxan diabetes which were studied were due primarily to effects of the alloxan on the pancreas, kidney, and carbohydrate metabolism, and that non-specific stress responses play little role in explaining these symptoms.

Brown, J. H. U., Emory University, Ga. "An Improvement of the Reddy Method for the Determination of 17-hydroxycorticoids in Human Urine," *Metabol.* 4:295-297 (July) 1955.

A method has been developed for the determination of 17-hydroxycorticoids in urine utilizing the Porter-Silber reaction. It has been possible to extract the "bound" as well and the free steroids from urine with the use of butanol as a solvent. In order to obtain complete recovery it was found necessary to adjust the pH to 2.5, to saturate the urine sample with sodium sulfate, and to extract with large volumes of solvent. Extraneous color is removed with the use of a five per cent sodium carbonate wash, and the wash is reextracted with additional butanol. Under these conditions it has been possible to determine the steroid content of five ml. of urine with good accuracy. The method has been used on patients, and it was found that the Addisonian patient excreted 0-2.5 mg./day in terms of cortisone, the normal excreted 4-10 mgs. and the Cushing's patient excreted 18-35 mgs./day. With this method recoveries approached 100 per cent of added cortisone. The values obtained with this method are about eight times as high as the values obtained with chloroform extraction, illustrating the ratio of bound to free steroids in human urine.

Wilhelmi, Alfred E., Grace E. Pickford and Wilbur H. Sawyer, Dept. of Biochemistry, Emory University, Ga. "Initiation of the Spawning Reflex Response in *Fundulus* by the Administration of Fish and Mammalian Neurohypophyseal Preparations and Synthetic Oxytocin," *Endocrinology* 57:243-252 (Aug.) 1955.

In the course of screening fractions derived from fish pituitaries for recognizable biological effects, it was observed that several of the fractions induced typical spawning behavior in the test organism, *Fundulus heteroclitus*, the Atlantic minnow. The reaction occurs in virgin normal fish and in both hypophysectomized and gonadectomized preparations. The reaction was not induced by any of the known anterior pituitary hormones. Quite by accident, it was found that both oxytocin and vasopressin are very effective initiators of the spawning reflex. A re-examination of the active fish pituitary fractions revealed that these were rich in posterior lobe hormone activity. Since a sample of synthetic oxytocin, kindly furnished by Professor Du Vigneaud, induced the response, it may be concluded that, in the fish, the neurohypophyseal hormones are responsible for the initiation of the spawning reflex response. The implications of this for the comparative biochemistry and physiology of the neurohypophysis are discussed.

Skelton, Floyd R., Medical College of Georgia, Augusta, Ga. "Experimental Hypertensive Vascular Disease in the Rat," *Arch. Path.* 60:190-200 (Aug.) 1955.

Hypertension and concomitant widespread vascular lesions have been produced by methylandrostenediol and by desoxycorticosterone acetate in the rat. These lesions are both acute and chronic, the former consisting of fibrinoid degeneration of vessel walls and the latter characterized by progressive connective tissue replacement of mural components. Renal lesions similar to malignant nephrosclerosis in the human have been produced by both steroids. Adrenal cortex of rats treated with methylandrostenediol contain intra-cellular globules the significance of which remains obscure.

The similarities between these experimentally produced vascular lesions and those observed in cases of malignant hypertension in the human being have been noted and their possible pathogenesis has been discussed.

Williams, George A., and Charles F. Whicker, Crawford W. Long Memorial Hospital, Atlanta, Ga. "Absence of the Left Diaphragm, An Unusual Complication in Pregnancy and Labor," *Obst. & Gynec.* 6:272-276 (Sept.) 1955.

A muscular diaphragm completely separating the celomic cavity and abdomen and thorax is found only in mammals. It is an essential organ of respiration and, as such, is extremely important in reproduction in the human. In addition to its function as a partition and as an organ of respiration, it becomes one of the most important muscles in the voluntary expulsive efforts of the second stage of labor. Obviously a defect in this important sheet of muscle may seriously complicate the course of pregnancy or parturition.

Diaphragmatic hernias other than those of minor degree about the esophageal hiatus are potentially grave complications of pregnancy. Those in which there is a large defect and the abdominal viscera are displaced into the thoracic cavity are especially serious. Thirteen cases from the literature are reviewed, and two from Atlanta are described. One (1930) died after cesarean section, and the other (1953) was successfully managed by means of midpelvic application of forceps at the beginning of the second stage of labor.

The overall mortality of 58 per cent in the cases reviewed should be lowered considerably by methods of management of pregnancy and labor now available. Every patient probably deserves an attempt of repair of the defect if it is discovered during the first trimester. Evidence of obstruction, strangulation, or perforation is an indication for immediate surgery at any stage of pregnancy.

Pregnancy should be terminated without allowing voluntary effort on the part of the patient which would increase all of the dangers common to abdominal hernias (incarceration, strangulation, and perforation) and also disturb the dynamics of respiration by causing a decrease in negative intrathoracic pressure and collapse of all or part of the lung on the involved side and shift the mediastinum to the opposite side with impairment of the function of that lung. Cesarean section seems to be favored generally but the authors see no reason why forceps should not be satisfactorily used unless obstetric contraindications exist.

Weens, H. Stephen, Jason L. Meadors, and William A. Reid, 36 Butler Street, S. E., Atlanta. "Intravenous Cholangiography and Cholecystography," *Surg.* 38:529-538 (Sept.) 1955.

Intravenous cholangiography and cholecystography were performed 48 times in 46 patients. The contrast medium used in this study was Cholografin. Only slight side reactions were noted, among which nausea and vomiting were most frequently encountered. All side effects were transitory and lasted no longer than five minutes, with the exception of one individual.

In 42 of a total of 48 examinations, liver function tests were carried out shortly before and within one to seven days following intravenous cholangiography. From these studies it appears that Cholografin, administered in doses currently recommended, will not impair liver functions to a degree recognizable by the test employed.

Opacification of the biliary tract and gallbladder was satisfactory in all normal individuals. It was not possible to opacify

the gallbladder in eight patients with acute cholecystitis. The examination in patients with clinical jaundice was not satisfactory with one exception. This patient was examined at the time the jaundice was decreasing.

The preliminary results obtained with the contrast medium warrants further exploration.

J. D. Martin, William C. McGarity, and Fred C. Smith, Emory University Hospital, Emory University, Ga. "Evaluation of ACTH and Cortisone in the Treatment of Burns," *Surg.* 38:543-552 (Sept.) 1955.

The effect of ACTH and cortisone in the treatment of badly burned patients admitted to Grady Memorial Hospital was studied in regard to their clinical and laboratory responses.

Previous investigations suggested that patients might be benefited by the administration of ACTH and Cortisone during the period of stress following the burn. The excessive and prolonged stress may lead to severe sequelae associated with adrenal cortical insufficiency. To determine the effect of these substances they were administered to 221 seriously burned patients during the first week following injury. Clinical and laboratory findings were correlated and studied. One of the most significant clinical findings was a decrease in pain. Several patients developed euphoria. Anorexia, nausea, and vomiting were also decreased. A fairly good appetite was noted which aided in maintaining a normal nutrition. Electrolytes, colloids, and fluids were easily controlled during treatment.

No serious objections were found from the use of ACTH and Cortisone in the treatment of burned patients. Although the mortality rate among these patients was not decreased, it is believed that borderline patients may be carried through the period of stress with the addition of ACTH and Cortisone to the routine treatment. However, the routine use of ACTH and Cortisone in treatment of burns is not indicated.

Williams, George A. and A. Cullen Richardson, 710 Peachtree St., N.E., Atlanta, Ga. "Endometriosis of the Cervix Uteri," *Obst. & Gynec.* 6:309-314 (Sept.) 1955.

The authors disagree with the suggestion that endometriosis of the cervix is an unusual or rare lesion. They find that it can be diagnosed readily at the time of the onset of the menstrual flow or shortly thereafter. Forty-two cases are reviewed from the literature and 35 of their own cases presented. The disease *per se* is of trivial importance but may produce alarming symptoms and occasionally present a disturbing appearance which must be differentiated from malignancy. Trauma to the cervix, either obstetric or operative, especially the latter, is probably an etiologic factor; only one patient in their series having experienced neither.

The incidence of primary and secondary sterility and spontaneous abortions among the patients is relatively high. An extremely high incidence of decidual reaction of the cervix in patients with endometriosis of the cervix who subsequently became pregnant suggests a causal relationship, but this cannot be established in any case.

Cervical endometriosis is usually successfully treated by light cauterization or fulguration of the lesion.

New Members of the M. A. G.

Name	Address	Society	Classification
Alfred M. Bennett	69 Butler St., S.E., Atlanta, Ga.	Fulton	Active
John M. Howard	Emory University Hospital, Emory U., Ga.	Fulton	Active
Henry M. Stenhouse, Jr.	265 Ivy St., N.E., Atlanta, Ga.	Fulton	Active
Tommy K. Stapleton	Pearson, Ga.	Walker-Catoosa-	Active
David P. Hall	Vanderbilt University Hospital, Nashville, Tenn.	Dade	Active
Isom C. Walker	18 East Taylor St., Savannah, Ga.	Ga. Medical Society	Active



physician's bookshelf

Kohl, Schuyler G., M.S., M.D., Dr. P.H., **PERINATAL MORTALITY IN NEW YORK CITY—RESPONSIBLE FACTORS**, Harvard University Press, Cambridge, 1955, 111 pp., 86 tables.

In view of the increasing recognition of the comparative and absolute lag in reduction of infant deaths in the prenatal, natal, and neonatal periods, this very careful, compact, and precise report of studies of factors responsible for the perinatal deaths of 955 infants in this special period of life should be of interest to students, practitioners of medicine, to hospital administrators, and to public health personnel. Hospitals, physicians, nurses, a health department, and a school of public health cooperated to provide information on which the panel of physicians proceeded. The same panel of physicians made decisions throughout. The cases were resubmitted to determine consistency. There is a concise summary—five pages.

The statistical definitions are clearly stated and simple. This is not true in all reports on this subject. The only questionable definition relates to qualifications of medical attendants. Board eligibility or board membership is apparently the dividing line between “qualified” and “unqualified.” This will be disturbing to those located in areas where the general practitioner is entirely responsible and does an excellent job. The reader can profit regardless of this limitation.

Briefly, the study shows that in the opinion of the panel, 35 per cent of the deaths (312 of 955) were preventable. One-third of the 955 infants died either because of shortcomings in their care in the prenatal period, during or after delivery, or because of negligence or ill-judged actions by the family. There are implications for improvement of these factors.

Toxemias of pregnancy occurred in mothers of 16 per cent of the infant deaths studied. In the opinion of the publishing group, about one-half could have been saved.

High infant loss was associated with births in which there was some type of operation or manipulation. In particular the committee considered that 40 per cent of the perinatal deaths associated with cesarean operations could have been prevented by wiser use of this procedure.

Unsatisfactory pediatric care was significantly frequent in the late neonatal deaths (6th to 30th day). This group comprised 234 of the 955. It was felt that it was among the mature infants that those giving perinatal, intrapartal, and postpartal care have the greatest opportunity to save lives.

The study is particularly timely in that the Medical

Association of Georgia Maternal and Infant Welfare Committee has just reached the point where the broad principles and procedures outlined can be helpful in preparing and planning for a similar but probably more limited study in Georgia. Particularly important are the suggestions regarding collection and analysis of data, the professional composition of the reviewing panels, and the diversity of professions and organizations which have valuable contributions to make, both in the process of the study and in the solution of the problems.

Helen W. Bellhouse, M.D.

Shaw, James H., Ph.D., **FLUORIDATION AS A PUBLIC HEALTH MEASURE**, American Association for the Advancement of Science, Washington, 1954, 232 pp.

This small volume is one which recommends itself less to public health personnel (because of their ready access to more detailed data) than to practicing physicians and dentists and to those civic and governmental agencies in need of unquestionable scientific information assembled by recognized authorities. It is a ready source for answers to questions raised on efficacy, safety pharmacodynamics and engineering methods relating to the application of fluorides in the control of dental caries.

This present monograph is the third of a series published by the American Association for the Advancement of Science which collectively portray in a spectacular manner the development of the most phenomenally effective preventive measure in the annals of public health. The editor is a distinguished research worker and is, among other things, Assistant Professor of Biological Chemistry at the Harvard School of Dental Medicine. The series carries this development through three very normal stages extending over a period of 14 years. The first of these, *Fluorine and Dental Health*, is the published record of the AAAS symposium of 1940, and records the concern still existent because of mottled tooth enamel believed to be directly attributable to the ingestion of excessive amounts of fluorine occurring in the water of some communities. The second of the series, *Dental Caries and Fluorine*, was derived from the 1944 meeting of the AAAS and is concerned with the beneficial effects to be had from the ingestion of optimal amounts of fluoride contained naturally in some communal water supplies.

This latest in the series follows a natural sequence in that it pulls together the pertinent research and public health data which has accumulated over many years, beginning with a German report published in 1874 and another in *Lancet* on tooth culture in 1892; it compiles this summation of knowledge

into 11 appropriate categories and covers the major areas of interest in applying fluoridation as a public health measure. Each of the 11 has been prepared by recognized researchers and workers and includes such authorities as Edward J. Largent of the Kettering Laboratory, University of Cincinnati College of Medicine, on the "Metabolism of Inorganic Fluorides"; a group in the National Institute of Dental Research, U.S.P.H.S., on "Medical Aspects of Excessive Fluoride in a Water Supply," and nine other individuals or groups of equal competence.

Fluoridation as a Public Health Measure is well-written and thoroughly documented. It leaves no doubt as to the overwhelming desirability of fluoridation as the practical, inexpensive, and almost universally applicable method of reducing by 60 to 70 per cent the incidence of a disease which accounts for untold misery and an annual expenditure by the American public of over \$1.6 billion—or about 15 per cent of the total health dollar expended for all purposes.

John E. Buhler, D.D.S.

Masserman, Jules H., M.D., **THE PRACTICE OF DYNAMIC PSYCHIATRY**, W. B. Saunders Company, Philadelphia, 1955, 790 pp., \$12.00.

In this text the author extends his correlation of the various physiologic and psychologic concepts of behavior which he calls biodynamics to clinical psychiatry and to the practice of medicine and its specialties. In Part One, which deals with the psychiatric examination, there is a detailed description not only of the procedures but also the cautions which must be exercised. Psychiatric diagnosis is presented as an appraisal of the patient's problems of adaptation rather than as a product of a diagnostic "pigeon holing."

Part Two, which consists of the description of various syndromes, conforms in general to the 1952 revision of *Standard Nomenclature of Nervous and Mental Diseases* but makes allowance for the fact that psychiatric problems which the physician meets in actual practice are not always identical with the classification groupings.

Part Three is devoted to the preparation of reports to physicians, jurists, insurers, marriage counselors, and others with whom the physician must deal.

Part Four is predominantly theoretical, and the author suggests that it may be omitted by those not immediately concerned with its content.

Part Five, the major portion of the book, is devoted to treatment which is limited to the various forms of psychotherapy. There is a review of the history and the various theories.

Generous use is made of illustrative case histories throughout the text.

The appendix contains a condensed outline for the psychiatric portion of the general medical examination. There is an excellent bibliography.

This book will be very helpful to the psychiatric resident. Physicians who are interested in evaluating their patients from a psychiatric point of view and in the principles and application of psychotherapy will find this book useful.

Joseph S. Skobba, M.D.

Deutschberger, Otto, M.D., **FLUOROSCOPY IN DIAGNOSTIC ROENTGENOLOGY**, W. B. Saunders Company, Philadelphia, 1955, 771 pp., 888 illustrations, \$22.00.

The author presents in one text a rather complete treatise on the use of the fluoroscope as an aid to diagnosis. For the radiologist, it is a good review and reference text. For the general practitioner who occasionally makes use of the fluoroscope, the section on hazards to patient and also to physician and how to prevent them is invaluable. Had this information been freely disseminated to all physicians and dentists several years ago, many cases of serious radiation damage to hands and fingers could have been avoided. For the student taking up radiology as a specialty, this text is a valuable addition to the available textbooks in radiology, which only a few years ago were a relatively scarce article. The illustrations and diagrams are very good, and the subject matter is well presented.

Neal F. Yeomans, M.D.

Wilkes County Medical Society is 50 Years Old

(On this and the following page is Dr. A. W. Simpson's description of the early history of one of Georgia's oldest county societies. It was presented originally at the Fiftieth Anniversary Celebration,

September 5, 1955, and should be of interest to all Georgia physicians—Ed.)

BACK IN THE EARLY 1900's the question of a county medical society was discussed by some of our doctors, and as a result letters were sent to the following Wilkes County physicians: J. E. Amason, Ralph Comer, C. E. Earle, John J. Hill, R. J. McNeill, J.

W. Ramsey, H. M. Sale, G. W. Sherrer, R. A. Simpson, J. A. Stapler, A. W. Simpson, H. C. Walton, and T. J. Willis, calling a meeting at the Courthouse on September 5, 1905, to organize a county society. At this meeting the Wilkes County Medical

Society was organized with T. J. Willis, president, and A. W. Simpson, secretary-treasurer.

All of the charter members of this society except one have gone to their reward.

It is especially interesting to note that our charter, dated September 29, 1905, 50 years ago, was signed by W. Z. Holliday, of Augusta, who had just recently been elected President of the Medical Association of Georgia. Dr. Holliday was born and reared in Wilkes County.

We of Wilkes County are also proud that William S. Armstrong, who was professor of surgery in the old Atlanta Medical College and at the time of his death Chairman of the Grady Hospital Board, was a native of Wilkes County.

Also Hunter P. Cooper, who was professor of anatomy in the Atlanta Medical College and who with W. S. Elkin operated one of the earliest private hospitals in Atlanta, was born and reared in Washington, Georgia.

It is most interesting to know that the noted Louis Alexander Dugas, who was referred to by Thomas W. Goodwin in his recent splendid talk before the Augusta Kiwanis Club, was born in Washington, and lived here the early years of his life. His parents were refugees from the French Revolution. His mother (Mrs. Poalien Dugas) had a private school here for girls in 1805.

Dr. Dugas' father (Lewis Dugas) died in Washington (1808) and some years later his mother with her family moved to Augusta, Ga., where he became a noted surgeon and was professor of surgery in the old Augusta Medical College, performing the first abdominal operation in the world when he sutured a patient's cut intestines with a violin string—Dr. Goodwin states that the patient recovered.

Fifty years ago, in horse and buggy days, when doctors carried saddlebags or small medicine cases containing drugs most needed—calomel, quinine, compound jalap powders, tincture of digitalis, Norwood's tincture of Veratrum (many of these old medicines are still useful), riding on horseback or in buggies over almost impassable roads, crossing streams with many fords and few bridges often swollen by recent rains; with epidemics of typhoid fever, smallpox, dyptheria, whooping cough, and many others, with the ever present mosquito and malarial fever; operating in the patient's home on the kitchen table, sometimes by light from kerosene lamps, with chloroform as an anesthetic, using instruments which had been boiled in a dishpan on the kitchen stove—the practice of medicine was not so easy then as it is today when we have good roads, modern means of transportation, more and better hospitals, improved sanitation, the use of modern

drugs, preventive medicine and up-to-date methods in anesthesia and surgery.

As early as December 1905 the question of establishing a county hospital was discussed by our society, but not until some years later when the doctors presented the question of building a hospital to the Washington Kiwanis Club was it immediately acted upon. Together with the Kiwanis Club, funds were raised by public subscription and the hospital built and opened for service in 1924. Down through the years since, our hospital has rendered valuable service to the people of Wilkes and surrounding counties.

Today it is a 60 bed hospital, well equipped and under excellent management and personnel.

From its organization our society has held regular monthly meetings. At these meetings different members reported unusual medical or surgical cases occurring in their practices. On occasions slides and pictures were shown of rare cases, and frequently we have had distinguished speakers present and discuss different medical or surgical subjects.

In the local newspaper, the *Gazette-Chronicle*, of October 4, 1905, is reported one of the earliest meetings of the society which gives an idea of what the programs were like:

“WILKES OUNTY MEDICAL SOCIETY. This Society held its regular meeting in the Courthouse on Tuesday morning. It is a branch of the State Association, and a physician cannot be a member of that body unless he is a member of the local organization. It meets every first Tuesday in the Courthouse.

“On Tuesday general business was attended to and special papers were read by Dr. T. J. Willis and Dr. R. A. Simpson. These were followed by an open discussion by different members of the Society.

“Dr. J. J. Hill addressed the meeting on the good of the Society to physicians as well as to the general public.

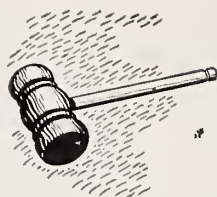
“The Society proposes to discuss the different diseases and the best prevention and cure of them, and would like to have the interest of the people generally enlisted in the matter.”

Since 1924 our meetings have been held in the hospital or in the office of one of the local doctors. For the past two years we have held alternate meetings with the McDuffie County Medical Society, and several times we have had the privilege of entertaining the Tenth District Medical Society.

It is very appropriate that the officers elected for 1955, our 50th Anniversary Year, were C. E. Willis, president, Dr. Willis is the son of T. J. Willis, the society's first president; and A. W. Simpson, Jr., was elected secretary-treasurer. Dr. Simpson is the son of A. W. Simpson the society's first secretary-treasurer.

A. W. Simpson, M.D.

president's page



THE SIXTH DAY OF JULY this year was the 70th Anniversary of Louis Pasteur's first injection of anti-rabies vaccine into Joseph Meister, an Alsatian boy who had been bitten 14 times by a rabid dog. Twenty years later I was bitten by an apparently rabid dog which came to its death in such an unusual manner that the incident was investigated by Robert Ripley and reported as a "Believe it or Not."

After having my slight wound cauterized with carbolic acid my parents and I learned of Dr. James N. Brawner and his Pasteur Institute, and I was taken to Dr. Brawner for prophylactic treatment. This was my first introduction to the scientific methods of Pasteur. I was privileged to see the hole bored into the rabbit's skull and the brain inoculated, the dumb type of rabies develop, and the post-mortem spinal cord desiccated and aged to attenuate the virus, some of this being injected into me.

At this time the State Board of Health was just beginning competition with Dr. Brawner, producing and distributing the anti-rabies vaccine to any physician without cost, to be administered to any victim of a dog bite. They were also examining without cost brains of dogs to verify whether rabies existed or not. I also know on good authority that Dr. Brawner never raised an issue of unfair competition but rather welcomed the wider distribution of a preventive measure for a rare but most horrifying disease.

Viral diseases in general are specie specific to a large extent, and perhaps not more than five per cent of humans bitten by rabid dogs would develop rabies even if untreated, but changing chances from one out of 20 to even one out of 100 is a great comfort to a youngster at the elementary arithmetic age.

H. D. Allen, Jr.

Mental Health Committee

Milledgeville, August 7, 1955

THE FIRST MEETING of the 1955-56 Committee on Mental Health of the Medical Association of Georgia was held at Milledgeville State Hospital on August 7. The meeting was called to order at 10:30 a.m. by Rives Chalmers, Chairman, in the offices of the Superintendent, T. G. Peacock. Members of the committee present were: Rives Chalmers, J. R. Shannon Mays, George H. Alexander, T. J. VanSant, and Arthur M. Knight, Jr. Also present were consultants to the committee, T. G. Peacock and Guy Rice. H. Dawson Allen, President of the Medical Association of Georgia, and Mr. John F. Kiser of the MAG Headquarters Office.

After a brief discussion led by Dr. Peacock of the facilities at the hospital, a tour of the grounds was conducted by Dr. Peacock in the hospital bus. Dr. Peacock explained that the staff included 40 physicians and 1,900 employees. The committee members also visited the hospital building and saw the laboratory, operating rooms, pathology department, and certain wards in the hospital.

After a luncheon served in the hospital administration building, the committee meeting got under way at 2:00 o'clock. Dr. Chalmers outlined the scope of committee activities and in general discussed the work of MAG committees and explained how they function. Dr. Mays reported on the committee activities for 1954-55. The committee agreed to support and work to implement in every way possible the recommendations of May 1955 with special emphasis on development of centers for residency training, treatment, and research at State Hospital.

Dr. Chalmers presented the report of the Governor's committee on training and research in mental health and described the activities of the Southern Regional Education Board in this respect.

Dr. Alexander presented the viewpoint of the general practitioner in regard to the treatment of mentally ill persons in the state. Then followed a discussion on commitment laws by Drs. Alexander, Chalmers, Peacock and Knight. Dr. Knight made the suggestion that the committee sponsor a booklet containing a condensed version of all commitment laws in the state, and this was referred to the Subcommittee on Education.

Dr. Peacock then discussed hospital standards set up by the American Psychiatric Association and explained how far these were from the actual practical viewpoint which exists in Georgia. He explained that the hospital would need \$16,000,000.00 instead of \$8,000,000.00 in order to accomplish 50 per cent of the recommendations made by the APA Board of Accreditation. Dr. Peacock went further to discuss the general field of hospital standards and explained some of the needs of the Milledgeville State Hospital.

Following these reports Dr. Chalmers discussed the areas in which he felt the committee should work during the coming year. He felt it was a function of the committee to educate the members of the Association in regard to treatment of the mentally ill in the state and also to formulate a policy to be adopted by the entire Association in regard to medical care and treatment of the

mentally ill. There followed considerable discussion along these lines and the problem of the isolation of the psychiatrists from other branches of medicine was discussed by Drs. Allen, Knight, Mays, and Alexander.

Dr. Chalmers appointed two subcommittees to function between meetings of the committee. The two subcommittees were set up so that the psychiatrists would be in one subcommittee with one general practitioner, and the other medical specialists would be in another subcommittee with one psychiatrist to act as liaison. Arthur M. Knight, Jr., is Chairman of the Subcommittee on Education with members of the committee: T. J. VanSant, Carl Whitaker, P. T. Scoggins, Albert Kelley, and Guy V. Rice as Consultant. The Subcommittee on Policy was organized with Shannon Mays as Chairman and members Rives Chalmers, Paul Schroeder, George H. Alexander and T. G. Peacock as Consultant. It was decided that these two subcommittees would probably hold meetings sometime in the fall and that the next full meeting of the committee would probably be held at the end of November or the first part of December in Macon.

After more discussion concerning several matters such as the relationship of psychiatrists with psychologists, new mental health laws in other states, the organization of county medical society mental health committees, the organization of medical forums on mental health topics, etc., the meeting was adjourned. On behalf of the committee, Dr. Chalmers thanked Dr. Peacock for his kind hospitality and luncheon.

Executive Committee of Council

Atlanta, October 4, 1955

CHAIRMAN H. DAWSON ALLEN called the meeting to order at 8:20 p.m. on October 4, 1955, at the residence of Dr. and Mrs. Hal Davison, Atlanta.

The following members of the Executive Committee of Council were present: H. Dawson Allen, Milledgeville, Chairman; Hal M. Davison, Atlanta, President-elect; William Harbin, Rome, Past-President; David Henry Poer, Atlanta, Secretary; J. W. Chambers, LaGrange, Council Chairman; and Bruce Schaefer, Toccoa, Audit and Appropriations Committee Chairman.

Also present were Edgar Woody, Jr., Atlanta, MAG Journal Editor; Grady Coker, Canton, Legislation Committee Chairman; and Mr. M. D. Krueger, Executive Secretary.

Mr. Krueger presented the resignation of George T. Nicholson, Rural Health Committee Chairman, in a letter of September 10, 1955, addressed to H. Dawson Allen. It was the unanimous opinion of the Executive Committee that Dr. Nicholson should be prevailed upon to complete his term as Chairman of the Rural Health Committee (May 1956).

A letter dated September 20, 1955, from the Assistant Secretary of the AMA concerning a one day conference of representatives from constituent medical associations for the study of the proposed disability amendments to Title II Social Security Act was presented to the committee by Mr. Krueger. Expenses of the representative were to be paid by AMA. On motion (Poer-Schaefer) William Harbin was appointed the MAG representative to attend this October 22 AMA Social Security meeting. J. W. Chambers was named alternate.

An AMA Council on Mental Health meeting to be held November 18 and 19, 1955, at the AMA headquarters, Chicago, to which constituent state medical associations were asked to send representatives, was brought to the attention of the Executive Committee by Mr. Krueger. He stated that the Mental Health Committee had no appropriation for the year and if a member of the Mental Health Committee were to attend this meeting, an appropriation for travel and hotel expense would have to be authorized. It was unanimously approved that the Medical Association of Georgia have a representative at this meeting and that the representative be the Chairman of the Mental Health Committee or an alternate designated by Dr. Allen, and that travel and hotel expenses be authorized by the Executive Committee.

Legislation Committee Chairman Grady Coker presented eight proposals for legislative activity. These items were discussed at length, and the Executive Committee unanimously approved all of the items presented by Dr. Coker.

A visitation plan of certain MAG officers and Executive Committeemen to visit with Georgia Congressmen and discuss certain issues affecting the profession was presented by William Harbin. It was the unanimous opinion of the Executive Committee that the visitation should be deferred until after the November 6, 1955, AMA Legislative meeting in Atlanta, and that the ground work for this visitation plan should be done previous to that date. The committee was in complete accord with the visitation plan and approved it unanimously.

The matter of hospital-physician liability, after some discussion, was referred to the Legislation Committee.

Indoctrination of new county society members was discussed. This project was approved by the Executive Committee and referred to the Public Relations Committee for action.

Legal representation for the Association was reviewed and relevant correspondence was presented to the committee by Mr. Krueger. The Executive Committee recommended that the president appoint a committee to investigate this matter and report to Council at the December meeting. The President appointed Bruce Schaefer, Hal M. Davison and David Henry Poer.

The Governor's appointments to the State Board of Health for the Third, Fifth, and Tenth Districts were presented, discussed, and referred to Dr. Coker for further investigation. It was decided that the Executive Committee and Dr. Coker should have a breakfast meeting with the Governor at a future date, to be arranged by Dr. Coker.

A report concerning small county medical society mergers was given by Mr. Krueger, and it was recommended and approved that mergers be continued on an informal educational basis rather than by recommendation of Council.

Journal Editor Edgar Woody then presented data concerning advertising submitted to the *Journal*. (The Executive Committee of Council also functions as the Publications Committee of the *JMAG*). It was the unanimous opinion of the Executive Committee that this advertising should not be accepted at the present time. Dr. Woody also presented the matter of setting a *Journal* subscription price for residents and interns; on motion (Schaefer-Allen) the price of \$1.00 per year for residents and interns was approved, and also approved was the price of \$1.00 per year for undergraduate medical students.

Television program plans for a series of programs highlighting the work of the 25 MAG committees was approved by the Executive Committee and referred to the Public Relations Committee with the understanding that final approval (script, etc.) would rest with the Executive Committee.

The date and place of the December Council meeting were discussed, and George Dillinger's invitation to meet in Thomasville, Georgia, December 9, 10 and 11, 1955, was accepted.

The date and place of the November Executive Committee of Council meeting was discussed and this was referred to Drs. Allen, Chambers, and Poer for necessary action.

The Executive Committee reviewed a re-amendment to the present enabling act for the Talmadge Memorial Hospital as presented by Grady Coker. After some discussion, the Executive Committee referred this matter to the Legislation Committee with its approval.

The meeting was adjourned at 10:10 p.m.

Salk Polio Vaccine Distributed in Georgia

DISTRIBUTION OF THE first allotment of Salk polio vaccine from the federal government was completed in Georgia on October 26, and a new priority system has been established for the schedule of shots.

The State Health Department is sending the vaccine to local health departments to be administered by private physicians, who charge only for services, and by health department clinics, for children who receive clinic care.

According to John H. Venable, Assistant to the Director of the Georgia Health Department, the new

priority established by the State Advisory Committee includes children who have reached their first birthday, but have not reached their tenth. Also included are expectant mothers before the eighth month of pregnancy.

Previously, first priority was given children from ages five through nine, with children from one to four years, and pregnant women next. That order was established by the State Advisory Committee for the vaccination program of the National Foundation for Infantile Paralysis, which ended October 26.

ANNOUNCEMENTS

Official Tour to Nassau—For members of the American Medical Association has been arranged for December 2-10, immediately following the AMA Clinical Session in Boston. By invitation from the Bahamas Medical Association a special medical meeting will be held at the Jungle Club in Nassau on Wednesday, December 7 for which a certificate of attendance will be issued. Official tour folders, containing full information, may be secured by writing to AMA *Nassau Tour Headquarters* at 35 East Monroe Street, Chicago 3.

Sectional Meetings of the American College of Surgeons—Six sectional meetings to be held in cities throughout the U. S. and Canada during 1956 are as follows: Jacksonville, Fla., January 16-18; Philadelphia, Pa., Feb. 13-16; Milwaukee, Wis., Feb. 27-29; Colorado Springs, Colo., Mar. 5-7; Little Rock, Ark., Mar. 12-13; and Edmonton, Alta., April 23-25. Panels, symposia, papers, and medical motion pictures of greatest value to doctors practicing in the area are presented. For information write to Dr. H. Prather Saunders, Associate Director, American College of Surgeons, 40 East Erie St., Chicago 11, Ill.

Caleb Fiske Prize—Subject of this year's dissertation for the essay competition is "Use of Radio-active Isotopes in the Treatment and Investigation of Disease." Dissertation must be typewritten, double spaced, and should not exceed 10,000 words. Cash prize of \$350 is offered. For information write to the Secretary, Caleb Fiske Fund, Providence 3, R. I.

Mediclinics of Minnesota Eight Day Course—Fort Lauderdale, Fla., March 5-14, 1956. Course will consist of 32 hours of instruction made up of lectures and panel discussions on subjects having an everyday application in the general practice of medicine. It is approved by the A. A. G. P. for credit for postgraduate study. Advance reservations must be filed by November 15, 1955. Tuition fee will be \$50.00 payable in advance. For reservations address Mediclinics of Minnesota, 516 Medical Arts Bldg., Minneapolis 2, Minn.

New York University Short Courses—N.Y.U.-Bellevue Medical Center, New York City. Course in recent advances in the Diagnosis and Treatment of Poisonings, Dec. 5 through 7, 1955; actual testing of materials will be undertaken in the laboratories of the Chief Medical Examiner and Toxicologist of the City of New York. Problems of Infertility as related to both husband and wife, Dec. 5 through 7, 1955. Pediatric Cardiology, Dec. 5 through 9, 1955. For further information write: Dean, NYU Post-Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Nineteenth Annual Meeting of the New Orleans Graduate Medical Assembly—Feb. 27 through March 1, 1956, Municipal Auditorium, New Orleans, La. Eighteen guest speakers will participate in 54 discussions on many topics of current interest in addition to clinicopathologic conferences, symposia, color television, etc. On March 2nd a postclinical tour to the West Indies and Central America will begin. Details of the New Orleans meeting and the postclinical tour are available at the

office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

Tenth Annual Univ. of Florida Midwinter Seminar in Ophthalmology and Otolaryngology—Sans Souci Hotel, Miami Beach, Fla., Jan. 16 through 21, 1956. The lectures on Ophthalmology will be presented on Jan. 16, 17, and 18; those on Otolaryngology on Jan. 19, 20, and 21. For reservations contact the Sans Souci Hotel, Miami Beach.

Fourth International Congress on Diseases of the Chest—Cologne, Germany, August 19 through 23, 1956. The meeting is sponsored by the Council on International Affairs of the American College of Chest Physicians. The scientific program is being organized now and physicians who have carried out original work in diseases of the chest which they wish to present are invited to send outlines of their studies to Dr. Andrew L. Banyai, Chairman, Committee on Scientific Program, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Ill. For further information, write to the Executive Offices at the above address.

DEATHS

WILEY A. ADERHOLD, Carrollton, died on September 11, 1955, at the age of 76. Dr. Aderhold had been ill for some time previous to his death.

He was graduated from the Atlanta Medical College, now Emory University School of Medicine, in 1905 and had practiced general medicine for 50 years. A native of Carroll County, he had lived in Carrollton most of his life except for a brief stay in Bremen.

Dr. Aderhold was a member of the Clem Methodist Church.

Surviving are his wife, the former Miss Lillic Cash; a daughter, Mrs. Jack Barker of Carrollton; a son, Mr. Ray Aderhold, of Carrollton; three grandchildren; and four great grandchildren.

Funeral services were held on September 13, 1955, at the Tabernacle Baptist Church; interment was in the Carrollton City Cemetery.

CHARLES DANIEL BOWDOIN, Atlanta, died September 23, 1955, following a heart attack. He was 50 years old at the time of his death. Dr. Bowdoin was director of venereal disease control and chronic disease control for the Georgia Department of Health. Under his direction, Georgia's program of venereal disease control gained international renown. Syphilis case finding and treatment techniques developed and used in the Georgia program are now in common use throughout the world.

A native of Adairsville, Dr. Bowdoin graduated from Emory University and the Medical College of Georgia. He received the master of public health degree from Johns Hopkins School of Hygiene and Public Health in 1935. He was a member of the Fulton County Medical Society, the American Society of Tropical Medicine, the Georgia Public Health Society, the American Social Hygiene Association, and the American Public Health Association.

Dr. Bowdoin joined the State Health Department in 1935 as an epidemiologist. He was director of preventable disease from 1941 to 1948, director of venereal disease control from 1948 to 1954, and director of heart disease control since 1954.

He is survived by his wife; a son, Mr. C. D. Bowdoin,

(Deaths)

Jr.; and a daughter, Miss Karen Parker Bowdoin, all of Atlanta.

Funeral services were held on September 24, 1955, at Spring Hill, Atlanta.

WILLIAM FLETCHER FRIDDELL, Boston, died on October 9, 1955, at the age of 86.

A native of Douglas County, Dr. Friddell graduated from the old Atlanta Medical College and had practiced medicine for 56 years. He had lived in Boston for the last 40 years.

Dr. Friddell was a Mason and a charter member of the Whitesburg Lodge at Whitesburg. He was a member of the Methodist Church.

Surviving are his daughter, Mrs. Agnes Day, Ft. Collins, Colo.; a daughter-in-law, Mrs. Jewell Friddell, Thomasville; and three grandchildren. His wife, the former Miss Mary Coleman, died in 1953.

Funeral services were held in Thomasville with interment in Laurel Hill, Thomasville; C. K. Wall, Ernest Wahl, and L. L. Lundy were among the pallbearers.

J. L. GARDNER, Sulphur Springs, was killed on August 28, 1955, when struck by a train at a railroad crossing. He was 66 years old at the time of his death.

Dr. Gardner was a member of Walker-Catoosa-Dade Medical Society and had practiced in Dade County for over 40 years.

Funeral services were held at the Methodist Church in Lathanville, Ala.

OTTO WALTER (TOM) MEISSNER, Athens, died in an automobile accident near Athens on September 29, 1955, at the age of 44.

A native of Austria, Dr. Meissner graduated from the University of Vienna and did graduate work in ophthalmology at Meller Clinic, University of Vienna. His residency was served at Baptist Hospital in Birmingham, Ala., and Passevant Hospital in Pittsburgh, Pa. He served with the U. S. Army in World War II with the rank of captain. Dr. Meissner was for a time Chief of the Eye, Ear, Nose, and Throat Department at Lawson Veterans Hospital in Atlanta and was on the teaching staff of Emory University School of Medicine. He had practiced in Athens for the past 10 years.

He was a member of the American Board of Ophthalmology, the Georgia Ophthalmological Society, Clarke-Madison-Oconee Medical Society, and the Tenth District Medical Society of which he was secretary. He was also a member of the Exchange Club, the Elks, Athens Country Club, and was Superintendent of the Sunday School for the Congregation Children of Israel.

Dr. Meissner is survived by his wife, the former Miss Lola Burns; a son, David Max Meissner, Athens; and his parents, Dr. and Mrs. Max Meissner.

Funeral services were conducted on September 30, 1955, from the Temple, Congregation Children of Israel. Goodloe Erwin, John Howard, A. Paul Keller, Jr., John Stegeman, and Bothwell Traylor, Athens, were pallbearers. Members of the Clarke-Madison-Oconee Medical Society formed the honorary escort.

ALBERT W. REHBERG, Cairo, died September 16, 1955. Dr. Rehberg was 55 years old.

A native of Grady County, Dr. Rehberg attended Sparks College and graduated from old Emory College at Oxford; he received his M.D. degree from Emory School of Medicine and interned at Grady Memorial

Hospital. After specialized training in surgery, Dr. Rehberg moved to Cairo where he was associated in practice with W. A. Walker in the Cairo Hospital. Dr. Rehberg later bought the hospital and operated it until 1947 when it was sold to the county authority for use as a public hospital.

He was a member of the Grady County Board of Health, Kiwanis, and the Chamber of Commerce. He was also very active in the First Methodist Church and the South Georgia Conference; He taught a Bible class for more than 25 years and was widely recognized as a Bible scholar. He had served as a chairman of the Cairo school district trustees. He was a member of the American Legion and for many years had been local medical counsel for the Atlantic Coast Line Railroad.

Funeral services were held at the First Methodist Church of Cairo with interment in the Cairo Cemetery. Immediate survivors include his wife, the former Miss Lillie Collins; a daughter, Mrs. Earl W. Stapleton, Brunswick; and a granddaughter, Miss Rachel Stapleton, of Brunswick.

JAMES REUBEN WALLIS, Lovejoy, died September 18, 1955, at the age of 80.

A native of Lovejoy, Dr. Wallis had practiced there for 52 years after his graduation from the old Atlanta College of Physicians and Surgeons. He also graduated from the Atlanta School of Pharmacy.

A member of the Clayton County Medical Society, Dr. Wallis was a Mason and a Shriner. He belonged to the Lovejoy Methodist Church.

He is survived by his wife; a son, Mr. James R. Wallis, Jr., Warwick, Va.; and a sister, Mrs. R. L. Dixon, of Hampton.

Funeral services were held at the Lovejoy Methodist Church with burial in the Jonesboro Cemetery.

FORD WARE, Macon, died October 4, 1955, after a brief illness. A native of Augusta, Dr. Ware was graduated from the Medical College of Georgia and served his internship at the Tulane University Hospital and in New York.

He began his private practice in Cordele; from there he moved to Americus and thence to Macon in 1932.

He was a member of the Bibb County Medical Society and was a Mason and a Shriner.

Surviving are his wife, the former Miss Janie Lee Gardner of Macon; a daughter, Mrs. L. B. Holt of Winston-Salem, N. C.; two grandchildren; and two sisters.

Funeral services were held in the chapel of Hart's Mortuary with burial in Cordele. Pallbearers included Thomas H. Ross, Harold Atkinson, O. R. Thompson, Walter Mobley, H. G. Weaver, and T. M. Butler, all of Macon.

SOCIETIES

The FOURTH DISTRICT MEDICAL SOCIETY held its fall meeting at the Highland Country Club in LaGrange on October 16, 1955. Dinner was served at 7:30 and the meeting followed. Herbert D. Tyler, Thomaston, president of the society, presided. T. A. Sappington, secretary, read the minutes of the last meeting; these were approved as read. The secretary was instructed to write a letter of condolence to the family of Wallis Clark. Mr. Milton D. Krueger, of the MAG headquarters office, spoke to the members on the new professional liability

(Societies)

insurance program, and Mr. John F. Kiser, also of the headquarters office, spoke on the cultist problem in Georgia. It was decided that the next meeting of the society would be held in Newnan in May. There was discussion of the proposed constitution and by-laws and the type of program wanted at the meetings of the district society. Officers for the coming year were elected; they are as follows: J. W. Chambers, LaGrange, president; J. R. Turner, LaGrange, vice-president; and Alex P. Jones, Griffin, secretary-treasurer. Dr. Tyler informed the members of the society that the executive committee had recently nominated Virgil P. Williams and William Fackler to the State Board of Health. Governor Griffin is to select one of these men to represent the Fourth District on the State Board of Health. There being no further business, the meeting was adjourned.

The EIGHTH DISTRICT MEDICAL SOCIETY met on October 11, 1955, in Waycross. The main feature of the meeting was the cancer symposium and the presentation of cancer cases by doctors on the staff of the Ware County Hospital; those on the panel were Julian Quattlebaum, Savannah; Robert Pendergrass, Americus; Hollis Hand, LaGrange; Robert Major, Augusta; and Ashbell Williams, Jacksonville, Fla. Dr. Williams was the guest speaker also at the dinner later. He is president of the Florida Division of the American Cancer Society and a member of the National Board of Directors. Arthur M. Knight, Jr., Waycross, presented a paper on "Acute Renal Heart Failure." Van B. Bennett, Valdosta, president of the society, presided.

The ATLANTA GYNECOLOGICAL AND OBSTETRICAL SOCIETY, of which Charles B. Upshaw of Atlanta is president, met on September 30, 1955, at the Piedmont Driving Club, Atlanta, to hear an address by Seymour Romney, assistant professor of obstetrics at Harvard Medical School. Dr. Romney spoke on "Vascular Patterns in the Human Placenta."

BIBB COUNTY MEDICAL SOCIETY met on October 4, 1955, at Pinebrook Inn. Refreshments and dinner were served before the scientific program. Oscar Spivey moderated a panel of pediatricians and obstetricians discussing the Rh problem; other members of the panel were Charles Rumble, William Shirley, and Lon King, Jr. William Orr showed a short, locally produced film illustrating replacement transfusions.

FULTON COUNTY MEDICAL SOCIETY met on October 6, 1955, for dinner and scientific program; it was a closed session for members only—the topic under discussion was "Cultists in Georgia." Sterling Claiborne, Atlanta, was moderator of the panel discussion. Panel members were Mr. Harry S. Avery, Nashville, Tenn.; State Senator Everett Millican, Atlanta; Hal Davison, Atlanta; and Mr. John F. Kiser, assistant executive secretary of the MAG. The society has recently gotten out an illustrated directory of its members. The booklet contains pictures of most of the members in addition to their names, home and office addresses, telephone numbers, and specialties. The society is again sponsoring with the State College of Business Administration a series of 10 weekly seminars on medical terminology and public relations.

The GEORGIA MEDICAL SOCIETY met on October 11, 1955, with the Southeastern Society of Neurology and

Psychiatry to hear an address by James B. Craig, professor of neuropsychiatry at the College of Medicine of Ohio State University. He spoke on "The Psychological Impact of Surgery." Discussion following was led by B. C. Willis, Savannah. Dr. Craig is a native of Augusta, a graduate of the Medical College of Georgia, and he practiced in Savannah from 1946 until 1952.

RICHMOND COUNTY MEDICAL SOCIETY met on September 27, 1955, in Augusta to hear an address by Luther A. Longino, clinical associate in surgery at Harvard Medical School. His topic was "Surgical Emergencies in Children."

SOUTH GEORGIA MEDICAL SOCIETY met on September 15, 1955, at the Valdosta Country Club. Participating in the program were the following: Albert Rauber, assistant professor of pediatrics at Emory University, who discussed problems of normal growth and development; Robert Brown, also of Emory University, who discussed malignancies of the head and neck; and Mr. John F. Kiser, assistant executive secretary of the MAG, who gave a talk on problems that are now confronting the medical profession. Dinner and business session preceded the program.

TRI-COUNTY MEDICAL SOCIETY met on October 11, 1955, at the Forest Heights Country Club in Statesboro. Curtis G. Hames, past president of the society, was the speaker; he presented an interesting series of cartoons depicting unethical medical practices.

WILKES COUNTY MEDICAL SOCIETY met on September 29, 1955 to celebrate its 50th anniversary. The celebration included a barbecue and invitation golf tournament at the Washington Wilkes Country Club. The program for the anniversary celebration featured a history of the local society by A. W. Simpson, the only living charter member. (See page 552), as well as a talk by Harry T. Harper, Augusta.

PERSONALS

First District

ELLISON R. COOK, III, Savannah, presided at the Seventh Annual Meeting of the Georgia Heart Association held September 23 and 24 at the General Oglethorpe Hotel, Savannah. Moderators for sessions included ARTHUR M. KNIGHT, JR., head of the Waycross clinic; T. STERLING CLAIBORNE, former president of the association and head of the heart clinic at St. Joseph's Infirmary in Atlanta; and THOMAS A. MCGOLDRICK, JR., Savannah, a member of the association's board of directors. Dr. Cook was a delegate to the assembly of the American Heart Association at its meeting held in New Orleans in October; he also directed the panel discussion on personnel. Dr. McGoldrick was an alternate delegate.

MARVIN F. ENGLE, Darien, attended the Tri-State Obstetrical and Pediatric Seminar held in September at Daytona Beach, Fla. He was accompanied by Mrs. Engle. He also attended the meeting of the Georgia Heart Association held in Savannah.

F. R. MANN, FRANK MANN, JR., FRED A. SMITH, and DUNCAN B. McRAE, McRae, have recently become associated in the practice of medicine as the Telfair Medical Group. Their offices are in the corner of Second

(Personals)

Avenue and Parsonage Street, McRae. Early in September of this year, the Dr.'s Mann closed Dr. Mann's Hospital, where they have practiced since 1939.

At the recent meeting of the Georgia Heart Association in Savannah a film and symposium were devoted to what was termed, "a broad survey of the use of heparin as of 1955". The discoverer of heparin, JAY McLEAN, now director of radiation therapy at the Savannah Tumor Clinic, was on hand to hear it all. Dr. McLean discovered heparin while doing research at Johns Hopkins in 1915-16.

T. A. PETERSON, Savannah, president of the Association of Seaboard Air Line Railroad Surgeons, presided at their national annual convention in Savannah, October 17 through 19. J. C. METTS, Savannah, chief of staff of Memorial Hospital, was one of the speakers on the program.

CHARLES L. PRINCE, Savannah, presented a paper at a recent meeting of the Lynn County Medical Society in Cedar Rapids on "Kidney Stones: Their Treatment and Prevention of Recurrence".

PETER L. SCARDINO, Savannah, was on the program of the most recent meeting of the Kentucky State Medical Association. The subject of the paper was "Cancer of the Urinary Tract".

JULIAN RAY YOUMANS, formerly of Lyons, and Mrs. Youmans sailed on September 27 for London, England, where Dr. Youmans will teach and do neurological research at National Hospital of the University of London for nine months. Dr. Youmans is a graduate of Emory University School of Medicine and is on leave from the University of Michigan School of Medicine where he is a junior clinical instructor in neurosurgery.

Second District

M. B. BOWMAN, Albany, has been made a fellow of the International College of Surgeons.

ALBERT S. TRULOCK, JR., Albany, announces the removal of his offices to the Doctors Center, 1009 North Monroe Street, Albany, with practice limited to general surgery.

W. A. WALKER, Cairo, observed his 89th birthday anniversary on September 20, 1955.

ROBERT F. WHEAT, Bainbridge, was presented with a golden "T" at the September commencement exercises of the University of Tennessee Medical School. Dr. Wheat graduated from the old Memphis Hospital Medical College 50 years ago. The college was consolidated with the University of Tennessee College of Medicine in 1913.

Third District

A. RALPH MONACO, Columbus, announces the opening of his private laboratory, "The Monaco Laboratory," in Room 109, 416 Twelfth Street, with practice limited to clinical laboratory procedures, pathology and cytology.

Fourth District

E. T. ARNOLD, Hogansville, was one of the invited participants in the scientific conference sponsored by the Smith, Kline, and French Laboratories in September

in Philadelphia. The conference was devoted to a general discussion on recent medical developments. Dr. and Mrs. Arnold went to New Bedford, Mass., for a few days following the conference to visit Mrs. Arnold's brother and his family.

V. H. BENNETT, Gay, has been named Meriwether County Physician, taking the place made vacant by the death of R. B. GILBERT.

Twin boys were born on September 14th to Dr. and Mrs. DOUGLAS LAMAR HEAD, JR., Thomaston. The twins have been named James Douglas and Russell Lamar.

C. E. IRWIN, who has been associated with the Warm Springs Foundation since July 1, 1933, and Mrs. Irwin were honored at a farewell party given by employees of the Foundation recently. The reception was held at the new Foundation Clubhouse. Dr. Irwin, an orthopedic surgeon, has entered private practice in Atlanta. Among the out-of-town guests at the reception were Dr. and Mrs. DARIUS FLINCHUM, Columbus. Dr. Flinchum is now associated with Dr. Irwin in practice in Atlanta.

J. MORGAN KELLUM, Thomaston, attended the annual meeting of the International College of Surgeons, in Philadelphia September 12-15, where he was made a qualified fellow. Dr. Kellum is also a fellow in the American College of Surgeons.

CLARENCE B. PALMER, Covington, was the guest speaker at the October meeting of the Newton County Nurses Association. Dinner was served in the hospital dining room before the meeting. Dr. Palmer told about the Tennessee Valley Medical Association meeting held recently in Chattanooga and he described the work done by nurses during the Second World War.

TOFEY G. SMAHA, Griffin, was made a qualified fellow of the International College of Surgeons at their recent meeting held in Philadelphia.

Fifth District

JOHN M. ANDERSON, Atlanta, spoke at a recent meeting of the Barnesville Rotary Club. His topic was "What Takes Place in a Psychiatrist's Office"; he told of the fears and doubts which attended a patient's entrance into the physician's office. Dr. Anderson is a graduate of Emory University and the Medical College of Georgia; he is also a former resident of Barnesville.

EDGAR BOLING, Atlanta, was a guest speaker at the Seventh Annual Scientific Assembly of the South Carolina Academy of General Practice, held in Columbia on September 27 and 28. Dr. Boling's topic was "Rectal Polyps and Rectal Cancer".

Dr. and Mrs. JAMES N. BRAWNER, JR., Atlanta, were hosts at a dinner honoring officers, and their wives, of the Southern Psychiatric Association when that association met in Atlanta on October 2 through 4. Dr. and Mrs. RAYMOND S. CRISPELL entertained at their home at a breakfast in their honor also.

The Jonte Equen Memorial Lecture given annually by MURDOCK EQUEN in honor of his father, was presented at the Academy of Medicine, Atlanta, on November 10th. Guest speaker was Frederick A. Figi, head of the section of plastic surgery and laryngology at the Mayo Clinic. His talk, "Cancer of the Larynx".

(Personals)

was illustrated with motion pictures. Dr. Figi is a native of Nebraska and a graduate of the University of Nebraska. He has been associated with the Mayo Clinic since his graduation, first as a student and later as a teacher.

C. E. HALL, Atlanta, became Georgia's sixth life master in the Southern Conference Regional Bridge Tournament held recently in Chattanooga. With Mrs. Gertrude Smith, also of Atlanta, as a partner, Dr. Hall won first place in the mixed pairs play.

L. HARVEY HAMFF, Atlanta, has been appointed to serve on the national committee on detection and education of the American Diabetic Association. A native of Alabama, Dr. Hamff received his M.D. degree from Emory University School of Medicine; he is now clinical assistant professor of medicine at Emory.

WILLIAM G. HAMM, Atlanta, outgoing president of the American Society of Plastic and Reconstructive Surgery presided at the annual meeting of the society held in Atlantic City in September. More than 500 plastic surgeons from all over the U. S., Canada, Great Britain, and South America attended the meeting. In his presidential address, Dr. Hamm called upon plastic surgeons to avoid preoccupation with financial security and to concentrate on "single minded devotion to our profession".

LAMONT HENRY, Atlanta, is the new president of the Georgia Heart Association; he succeeds ELLISON R. COOK, III, Savannah, in that office.

At the meeting of the International College of Surgeons in Philadelphia in September, one of the featured speakers was J. HIRAM KITE, Atlanta, who advised the physicians assembled that too much "tummy down" sleeping may make a baby flat-footed or pigeon-toed. He said prevention of these conditions might be achieved by training the baby to sleep in various positions, preferably on his side.

JOHN R. LEWIS, JR., Atlanta, has been invited to join the Writers Club of Atlanta. Dr. Lewis is a native of Louisville.

ARTHUR J. MERRILL, Atlanta, served as co-chairman for the session on clinical cardiology at the meeting of the American Heart Association held in New Orleans in October. EUGENE FERRIS, professor of medicine at Emory, was co-chairman of the session on high blood pressure. CARTER SMITH, Atlanta, served as a delegate from the American Heart Association Board.

FREEMAN M. SIMMONS, president of the DeKalb County Medical Society, C. W. MORSE, and G. A. DUNCAN, all of Decatur, are three of the nine citizens of the county appointed by the county commissioner to study the hospital needs of DeKalb County and make recommendations as to satisfying those needs. Dr. Simmons is chairman of the committee.

W. VERNON SKILES, JR., Atlanta, has been made a fellow of the International College of Surgeons.

JOSEPH S. SKOBBA, Atlanta, is one of the two new vice-presidents of the Southern Psychiatric Association installed in October.

SCOTT TARPLEE, Atlanta, addressed a recent meeting of the Atlanta Kiwanis Club on the subject of obesity and nervous tension; their cause and effect on the length of a person's life.

The class of 1917 of Emory's medical school held its annual reunion at the Henry Grady Hotel in Atlanta on October 8th. CHARLES B. UPSHAW, Atlanta, is class councilman.

Sixth District

WALTER BARNES, Macon, announces that Edsel Dickey, a new orthopedic surgeon coming to Macon, will temporarily share his offices.

Six Macon physicians attended the meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago, October 9-13. They are BRASWELL COLLINS, JOHN MARTIN, DUNCAN WALKER, WILLIAM BARTON, DEVEREAUX JARRATT, and WILLIAM HOLDEN.

A very unusual birthday party was given in Gordon on September 13, 1955, by GEORGE W. DUPREE. The honor guests were three "babies" he delivered on the same Friday the 13th 26 years ago. The doctor had planned to hold the celebration when his guests were 13 years old, but circumstances prevented this; he waited 13 more years, and says that there will be another celebration in 13 years if all the guests can come.

MARVIN L. GREENE, Monticello, has returned from a Doctors' Tour to Europe. He visited Portugal, Spain, Italy, France, England, Germany, and Austria, where he attended the World Medical Congress.

The *Journal* extends sympathy to JOHN R. LEWIS, JR., Louisville, on the death of his mother, Mrs. Nonie Dillard Lewis, on September 8, 1955. A resident of Sparta, Mrs. Lewis had lived in many towns in Georgia with her husband, the late Reverend John R. Lewis, Sr., who was superannuated from the North Georgia Conference. Mrs. Lewis is a sister of J. B. DILLARD, Davisboro.

JULE C. NEAL and W. C. SHIRLEY, Macon, announce their association in the practice of obstetrics and gynecology with offices in the Professional Building.

Among those attending the meeting of the Georgia Heart Association in Savannah, September 23-24, were TOM ROSS, ALLAN COLE, BOB IRELAND, BEVERLY FORESTER, HOLLOWAY BUSH, WADDELL BARNES and HENRY TIFT.

LARRY A. SCHWARTZ, Macon, announces the opening of his office at 2308 Ingleside Avenue for the practice of pediatrics. A native of Macon, Dr. Schwartz was graduated from Mercer University. He served with the U. S. Air Force in Japan and at Robins Air Force Base and has done postgraduate work in pediatrics at Charity Hospital in New Orleans, La.

Seventh District

R. L. BENSON, a native of Marietta, has assumed the duties of Commissioner of Health for the Whitfield-Murray Health Department. He fills the vacancy created last March by the death of D. L. BUTTERFIELD. Dr. Benson is a graduate of Mercer University and the Medical College of Georgia. He interned at Athens and took an orientation course in public health work at the Fulton County Health Department.

RAYMOND F. CORPE, Rome, was chairman of the medical session at the joint meeting of the Georgia Tuberculosis Association and Georgia Trudeau Society held on October 20th in Atlanta. HORACE E. CROW, Rome, and ROBERT C. MAJOR, Augusta, led discussions in this session.

FLOYD W. MORGAN, Douglasville, has been appointed by the director of the State Crime Laboratory and the director of Public Health to serve as medical examiner for Douglas County.

FRED K. SCHMIDT, Marietta, who has recently returned from Korean service with the armed forces, addressed the Lions Club on his experiences in Korea. He illustrated his talk with slides.

Eighth District

B. H. Cogdell, formerly of Lake Charles, La., has moved to Nicholls and assumed the practice of JACK DULEY. He will occupy offices in the Nicholls Medical Clinic. A native of Texas, Dr. Cogdell graduated from Hardin Simmons College, Tulane University, and Tulane Medical School; he served his internship at the Southern Baptist Hospital in New Orleans. He had practiced in Lake Charles for one year before coming to Nicholls.

Mr. and Mrs. G. W. R. Davidson of Macon have announced the engagement of their daughter, Miss Eleanor Mildred Davidson, of Atlanta and Macon, to DARRIEL GYE KITCHENS, of Augusta and Savannah. Dr. Kitchens is a graduate of the Medical College of Georgia; he is at present a resident in internal medicine at University Hospital, Augusta.

OWEN K. YOULES, JR., formerly of Augusta, announces the opening of his office in the Little-Griffin Hospital Building in Valdosta. Dr. Youles is a native of Valdosta; he graduated from Emory University and the Medical College of Georgia. He served his internship at Georgia Baptist Hospital in Atlanta and has had three years residency at the University Hospital in Augusta.

Ninth District

MARTIN SMITH, Gainesville, was speaker at a recent meeting of the Cornelia P.-T.A. His topic was "Childhood Diseases, Their Prevention and Cure." A panel discussion followed his talk; participating in the discussion were J. J. ARRENDABLE, Cornelia, B. J. ROBERTS, Cornelia, and F. O. GARRISON, Demorest.

Tenth District

C. H. Dickens, Madison, attended the Tri-State Post-graduate Obstetric and Pediatric Seminar held in September at Daytona Beach, Fla. Mrs. Dickens accompanied Dr. Dickens to Florida for a vacation while he attended the meeting.

ROBERT C. MAJOR, Augusta, was a guest speaker at the Seventh Annual Scientific Assembly of the South Carolina Academy of General Practice held in Columbia on September 27 and 28, 1955. His topic was "Indications and Preparation of the Patient for Pulmonary Surgery." Dr. Major is clinical professor of surgery at the Medical College of Georgia and is in the private practice of thoracic surgery in Augusta.

There has been but one case of polio in Elberton this year: three year old Peggy O'Neal, daughter of JOHN B. and PHYLLIS J. O'NEAL. We hope that Peggy has a speedy and complete recovery.

EDGAR R. PUND, Augusta, president of the Medical College of Georgia, has been appointed "Expert Consultant to the Surgeon General of the U. S. Army" for a 30 day inspection and lecture tour of the medical facilities of the U. S. Army in the Far East. Dr. Pund left Washington on September 30th and visited installations in Japan and Korea.

Mr. and Mrs. Harold LaRoche, of Aiken, S. C., have announced the engagement of their daughter, Miss Anna Marie LaRoche, of Augusta, to BITHEL WALL, Augusta. Dr. Wall is in the private practice of urology in Augusta.

A. M. A. Ninth Clinical Meeting to be in Boston

QUAINT OLD BOSTON with its crooked streets and historic landmarks familiar to every American school-boy has much to offer physicians and their wives planning to attend the AMA's ninth annual Clinical Meeting November 29 to December 2. An outstanding scientific program covering all phases of medicine—including lectures, round table discussions, color television and motion picture films—has been lined up for AMA visitors. In the Scientific Exhibit leading authorities from all over the country will be on hand continuously throughout the four-day meeting to answer questions and discuss problems with

doctors. The Technical Exhibition will feature the latest developments in equipment, books and pharmaceuticals.

This year's meeting promises to be one of the largest Clinical Sessions on record. Both the Scientific and Technical Exhibits will be held in the Mechanics Building, and the House of Delegates will meet at the Statler Hotel. Arrangements are being completed to make this session a worth while post-graduate medical education "course." Plan now to attend!

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1955 by the Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; 1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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COVER

The cover, depicting the U. S. capitol in Washington, D. C., and the Georgia capitol in Atlanta, should serve to remind all physicians reading this issue of the part they can and should play in the legislation of the nation and state. Photo by Ted F. Leigh, M.D.

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W. C. Baxley, Blakely, President
R. B. Quattlebaum, Ft. Gaines, Secretary

SPALDING

T. J. Floyd, Griffin, President
Jackson W. Landham, Griffin, Secretary

STEPHENS

W. H. Good, Toccoa, President
C. L. Ayers, Toccoa, Secretary

SUMTER

Bon M. Durham, Americus, President
Russell Thomas, Americus, Secretary

TATTNALL

H. M. Hughes, Glennville, President
A. G. Pinkston, Jr., Glennville, Secretary

TAYLOR

Lewis Beason, Butler, President
E. C. Whatley, Reynolds, Secretary

TELFAIR

F. A. Smith, McRae, President
D. B. McRae, McRae, Secretary

THOMAS-BROOKS

Kirk Shepard, Thomasville, President
Julian Neel, Thomasville, Secretary

TIFT

C. S. Pittman, Sr., Tifton, President
E. M. Flowers, Tifton, Secretary

TROUP

J. C. Morgan, Jr., West Point, President
E. W. Molyneaux, LaGrange, Secretary

UPSON

Wm. J. Gower, Jr., Thomaston, President
H. D. Tyler, Thomaston, Secretary

WALKER-CATOOSA-DADE

L. L. Alexander, Rossville, President
E. M. Townsend, Ringgold, Secretary

WASHINGTON

C. D. Briscoe, Monroe, President
Ernest Thompson, Monroe, Secretary

WARE

Floyd Davis, Waycross, President
A. M. Knight, Waycross, Secretary

WARREN

H. B. Cason, Warrenton, President
A. W. Davis, Warrenton, Secretary

WASHINGTON

O. D. Lennard, Tennille, President
Wm. Rawlings, Sandersville, Secretary

WAYNE

R. A. Pumpelly, Jesup, President
H. G. Glover, Jesup, Secretary

WHITFIELD

Willard Carson, Chatsworth, President
Lloyd C. Yeargin, Dalton, Secretary

WILKES

C. E. Wills, Sr., Washington, President
A. W. Simpson, Washington, Secretary.

WORTH

Norman Crowe, Sylvester, President
W. P. Stoner, Sylvester, Secretary

You're Elected, Doctor

Within a few weeks the 1956 Georgia General Assembly will convene to consider legislation in the interests of the citizens of Georgia. Competent legislators, acting in behalf of their constituents, will vote for and against measures affecting all of the people of this state. The Representatives and Senators will, to the best of their ability, seek to improve the economy, health, and welfare of the people.

Physicians, because of their education, training, and experience in the healing arts, are authorities in matters related to the health of the people. As such, the doctors of Georgia must bear their civic responsibility in making information available and advising government representatives in the field of health. To do less than this would be breaking faith with the tenets of the medical profession.

Who can better advise than the physician who has dedicated his life to the alleviation of suffering, to the enhancement and prolongation of life, and to the destinies of humanity? Who is better qualified to advise than the physician whose daily practice gives him special insight into the problems of medical care? Who then, if not the physician, can assume the responsibility of counsel on these matters?

The doctor is elected—elected by his desire to practice medicine and his qualification to practice—elected to initiate, advise, and guide on all problems of health. The physician who ignores or evades this responsibility is not truly a doctor. It is not enough for the doctor to treat his individual patients and practice his art each day. The doctor must be concerned with the health of all people and any measures that may affect the public health. The doctor

cannot remain content to limit his activity to the care of the infirm—he must recognize his useful rank among the vast concourse of citizens on whose shoulders the destiny of our state rest.

The doctors of Georgia, in recognizing their responsibility, are supporting certain proposed medically related legislation. Care of the indigent, the “cultist” problem, and the corporate practice of medicine are problems requiring legislative consideration. These issues will be presented to the Georgia General Assembly. The legislators will call upon leaders of the medical profession to explain and clarify these and other health matters so that the legislator may vote intelligently with accurate and complete information. Doctors in every county will be asked about these matters—and doctors in every county must take the responsibility of providing information to their legislators on these matters.

Georgia physicians must come forward and give of their expert knowledge to inform men elected and empowered to make the law affect the citizenry's health. If the physician is not sought out by the legislator, the physician must seek out the legislator. As a physician and citizen, the doctor is performing a service for the betterment of public health and a civic duty when he counsels on these matters.

Legislators are listed on the following pages for your convenience. Know your Senators and Representatives and fulfill your responsibility.

Milton D. Krueger

Executive Secretary

Members of the SENATE OF GEORGIA By Districts in Numerical Order with Counties and Post Offices

First District—CHATHAM, Effingham
OWEN H. PAGE, JR. Savannah

Second District—BRYAN, McIntosh, Liberty
CHAS. F. WARNELL Groveland

Third District—BRANTLEY, Wayne, Long
JOSEPH BARNEY STRICKLAND Nahunta

Fourth District—CHARLTON, Glynn, Camden
ALVA J. HOPKINS, JR. Folkston

Fifth District—WARE, Atkinson, Clinch
W. K. PONSELL Waycross

Sixth District—ECHOLS, Lowndes, Lanier
J. L. WETHERINGTON Jasper, Florida

Seventh District—THOMAS, Grady, Mitchell
LAWSON NEEL Thomasville

Eighth District—DECATUR, Seminole, Miller
REUBEN M. REYNOLDS Bainbridge

Ninth District—CALHOUN, Early, Baker
CHARLES E. DEWS Edison

Tenth District—LEE, Dougherty, Worth
JAMES M. McBRIDE Leesburg

Eleventh District—RANDOLPH, Terrell, Clay
N. C. COFFIN Cuthbert

Twelfth District—QUITMAN, Stewart, Webster
THOMAS TOMS Georgetown

Thirteenth District—MACON, Schley, Sumter
A. CULLEN RICHARDSON Montezuma

Fourteenth District—BLECKLEY, Dooly, Pulaski
JAMES M. DYKES Cochran

Fifteenth District—MONTGOMERY, Wheeler, Toombs
WALTER B. MORRISON Mount Vernon

Sixteenth District—LAURENS, Treutlen, Emanuel
W. HERSCHEL LOVETT Dublin

Seventeenth District—JENKINS, Screven, Burke
WALTER HARRISON Millen

Eighteenth District—JEFFERSON, Richmond, Glascock
M. BRINSON JONES Wrens

Nineteenth District—WARREN, Taliaferro, Greene
E. DOUGHTY RICKETSON Warrenton

Twentieth District—BALDWIN, Hancock, Washington
ARNOLD PARKER Milledgeville

Twenty-First District—JOHNSON, Jones, Wilkinson
FRANCIS F. SHURLING Wrightsville

Twenty-Second District—MONROE, Butts, Lamar
J. KIMBALL ZELLNER Forsyth

Twenty-Third District—CRAWFORD, Peach, Taylor
W. T. JONES Roberta

Twenty-Fourth District—MUSCOGEE, Chattahoochee,
Marion
HOWELL HOLLIS Columbus

Twenty-Fifth District—HARRIS, Upson, Talbot
WILLIAM BURTON STEIS Hamilton

Twenty-Sixth District—SPALDING, Clayton, Fayette
E. GIRDEAN HARPER Griffin

Twenty-Seventh District—JACKSON, Barrow, Oconee
WILLIS NEAL HARDEN Commerce

Twenty-Eighth District—MORGAN, Jasper, Putnam
E. ROY LAMBERT Madison

Twenty-Ninth District—COLUMBIA, Lincoln, McDuffie
EDGAR D. CLARY, JR. Harlem

Thirtieth District—MADISON, Elbert, Hart
A. F. SEAGRAVES Hull

Thirty-First District—STEPHENS, Habersham,
Franklin
DR. C. L. AYERS Toccoa

Thirty-Second District—LUMPKIN, Dawson, White
ARTHUR E. HOUSLEY Dahlonga

Thirty-Third District—HALL, Forsyth, Banks
HOWARD T. OVERBY Gainesville

Thirty-Fourth District—DEKALB, Gwinnett, Rockdale
A. MELL TURNER Decatur

Thirty-Fifth District—WALTON, Henry, Newton
EUGENE KELLY Monroe

Thirty-Sixth District—COWETA, Meriwether, Pike
D. B. BLALOCK Newnan

Thirty-Seventh District—CARROLL, Troup, Heard
MARVIN C. ROOP Carrollton

Thirty-Eighth District—PAULDING, Haralson, Polk
B. M. JONES Dallas

Thirty-Ninth District—DOUGLAS, Cobb, Cherokee
GLEN FLORENCE Douglasville

Fortieth District—TOWNS, Union, Rabun
W. K. DEAN Young Harris

Forty-First District—GILMER, Pickens, Fannin
CHARLES E. WATERS Ellijay

Forty-Second District—BARTOW, Chattooga, Floyd
JEFFERSON L. DAVIS Cartersville

Forty-Third District—WHITFIELD, Gordon, Murray
C. ERNEST McDONALD Dalton

Forty-Fourth District—DADE, Walker, Catoosa
JOHN H. WILKINS Trenton

Forty-Fifth District—IRWIN, Ben Hill, Telfair
TILLMAN PAULK Ocilla

Forty-Sixth District—PIERCE, Bacon, Coffee
O. W. RAULERSON Patterson

Forty-Seventh District—COLQUITT, Tift, Turner
DORSEY R. MATTHEWS Moultrie

Forty-Eighth District—CRISP, Dodge, Wilcox
J. W. MANN Cordele

Forty-Ninth District—EVANS, Bulloch, Candler
T. J. WOOD Bellville

Fiftieth District—OGLETHORPE, Clarke, Wilkes
GEORGE B. BROOKS Crawford

Fifty-First District—TWIGGS, Houston, Bibb
HOMER L. CHANCE Danville

Fifty-Second District—FULTON
G. EVERETT MILLICAN Atlanta

Fifty-Third District—BROOKS, Berrien, Cook
H. R. GARRETT Quitman

Fifty-Fourth District—JEFF DAVIS, Tattnall, Appling
LAWTON R. URSREY Hazlehurst

Members of the GEORGIA HOUSE OF REPRESENTATIVES By Counties and Post Offices for the Term 1955 - 1956

County	Representative	Post Office	County	Representative	Post Office
Appling	W. C. "Bill" Parker	Baxley	Decatur	H. Carl Cloud	Climax
Atkinson	Waldo Henderson	Lakeland	Decatur	Vaughn E. Terrell	Bainbridge
Bacon	Braswell Deen, Jr.	Alma	DeKalb	James A. Mackay	Decatur
Baker	L. Cotton	Leary	DeKalb	W. Hugh McWhorter	Decatur
Baldwin	Joseph B. Duke	Milledgeville	DeKalb	Guy W. Rutland, Jr.	Decatur
Baldwin	W. C. Massee	Milledgeville	Dodge	Gilbert C. Peacock	Eastman
Banks	Tom Martin	Homer	Dooley	C. B. Brannen	Unadilla
Barrow	Robert L. Russell, Jr.	Winder	Dougherty	Jim Denson	Albany
Bartow	D. Vann Underwood	Cartersville	Dougherty	G. Stuart Watson	Albany
Bartow	Troy Upshaw	Rydal	Douglas	A. A. Fowler, Jr.	Douglasville
Ben Hill	A. L. Stewart	Fitzgerald	Early	Leon H. Baughman	Cedar Springs
Berrien	R. S. English, Jr.	Nashville	Echols	Louis T. Raulerson	Haylow
Bibb	J. Douglas Carlisle	Macon	Effingham	H. N. Ramsey, Sr.	Springfield
Bibb	Denmark Groover, Jr.	Macon	Elbert	Woodrow Wilson Lavender	Bowman
Bibb	Andrew W. McKenna	Macon	Emanuel	Geo. L. Smith, II	Swainsboro
Bleckley	Ben Jessup	Cochran	Evans	B. E. Smith, Sr.	Daisy
Brantley	J. Floyd Larkin	Hoboken	Fannin	Reid Mull	Blue Ridge
Brooks	John E. Sheffield, Jr.	Quitman	Fayette	Grady L. Huddleston	Fayetteville
Bryan	W. Roscoff Deal	Pembroke	Floyd	J. Battle Hall	Rome
Bulloch	Francis W. Allen	Statesboro	Floyd	Robert L. (Bob) Scoggin	Rome
Bulloch	Wiley B. Fordham	Statesboro	Floyd	Barry Wright, Jr.	Rome
Burke	Frank M. Cates	Waynesboro	Forsyth	Marcus Mashburn	Cumming
Burke	T. Watson Mobley	Girard	Franklin	Ralph Kelley Fain	Royston
Butts	B. Harvey Hodges	Jackson	Fulton	Hamilton Lokey	Atlanta
Calhoun	J. M. Cowart	Arlington	Fulton	Hoke Smith	Atlanta
Camden	John D. Odom	Kingsland	Fulton	M. M. (Muggsy) Smith	Atlanta
Candler	William L. (Bill) Lanier	Metter	Gilmer	Walter F. Johnson	Ellijay
Carroll	J. Ebb Duncan	Carrollton	Glascok	W. G. Todd	Gibson
Carroll	C. C. Perkins	Mount Zion	Glynn	William R. Killian	Brunswick
Catoosa	John W. Love, Jr.	Ringgold	Glynn	Bernard N. Nightingale	Brunswick
Charlton	H. Ben Rodgers	Folkston	Gordon	Henry A. Mauldin	Calhoun
Chatham	Frank S. Cheatham, Jr.	Savannah	Grady	R. A. Harrell	Cairo
Chatham	Edgar P. Eyler	Savannah	Greene	William L. Ruark	Woodville
Chatham	John W. Sognier	Savannah	Gwinnett	Paul V. Kelley, Sr.	Lawrenceville
Chattahoochee	Joe N. King	Cusseta	Gwinnett	Willie Lee Kilgore	Lawrenceville
Chattooga	James H. Floyd	Trion	Habersham	T. Sidney Blackburn	Alto
Chattooga	Paul B. Weems	Summerville	Hall	Wm. B. Gunter	Gainesville
Cherokee	Dr. Grady N. Coker	Canton	Hall	W. M. Williams	Gainesville
Clarke	Chappelle Matthews	Athens	Hancock	Marvin E. Moate	Sparta
Clarke	Robert G. Stephens, Jr.	Athens	Haralson	Harold L. Murphy	Buchanan
Clay	A. S. Killingsworth	Fort Gaines	Harris	W. D. Sivell	Chipley
Clayton	Edgar Blalock	Jonesboro	Hart	B. Benson Matheson	Hartwell
Clayton	E. Alvin Foster	Forest Park	Hard	W. O. (Ted) Barker	Franklin
Clinch	Downing Musgrove	Homerville	Henry	Edward E. McGarity	McDonough
Cobb	Fred D. Bentley	Marietta	Houston	John W. Bloodworth	Perry
Cobb	Raymond M. Reed	Marietta	Irwin	D. D. Hudson	Ocilla
Cobb	Harold S. Willingham	Marietta	Jackson	Mac Barber	Commerce
Coffee	Dewey Hayes	Douglas	Jasper	Wm. Hicks Key	Monticello
Coffee	Andrew J. Tanner	Douglas	Jeff Davis	J. I. Harrison	Hazlehurst
Colquitt	Leo T. Barber	Moultrie	Jefferson	J. Roy McCracken	Avera
Colquitt	H. Jack Short	Doerun	Jenkins	Merrill Johnson	Millen
Columbia	Glenn S. Phillips	Harlem	Johnson	Emory L. Rowland	Wrightsville
Cook	Lonnie H. Grimsley	Adel	Jones	George L. Jackson	Gray
Coweta	George W. Potts	Newnan	Lamar	Joe B. Adams	Barnesville
Coweta	David C. Stripling	Newnan	Lanier	Warren S. Moorman	Lakeland
Crawford	R. Clifton Murphey	Roberta	Laurens	Rubert L. Hogan	Dudley
Crisp	Palmer H. Greene	Cordele	Laurens	Paul J. Jones, Jr.	Dublin
Dade	Woodrow W. Gross	Avans	Lee	William M. Coxwell	Leesburg
Dawson	Carlton W. Gilleland	Dawsonville	Liberty	Roscoe Denmark	Hinesville

County	Representative	Post Office
Lincoln	John P. Drinkard	Lincolnton
Long	George W. Hendrix	Ludowici
Lowndes	J. E. Mathis	Valdosta
Lowndes	G. Troy Register	Valdosta
Lumpkin	Fred C. Jones, Jr.	Dahlonega
Macon	J. Lester Souter	Montezuma
Madison	Jere C. Ayers	Comer
Marion	E. C. Stevens	Buena Vista
McDuffie	H. Eulond Clary	Thomson
McIntosh	Mose Edenfield	Darien
Meriwether	Guy W. Hardaway	Greenville
Meriwether	Hoke S. Peters	Manchester
Miller	Lovette Dozier	Colquitt
Mitchell	Tom C. Palmer, Jr.	Pelham
Mitchell	Frank S. Twitty	Camilla
Monroe	Wm. B. Freeman	Forsyth
Montgomery	Joe C. Underwood	Mt. Vernon
Morgan	Howard H. Tamplin	Madison
Murray	Fred F. Long	Chatsworth
Muscogee	John Nilan	Columbus
Muscogee	A. Mac Pickard	Columbus
Muscogee	J. Gordon Young	Columbus
Newton	W. C. Ivey	Porterdale
Oconee	D. Mayne Elder	Watkinsville
Oglethorpe	Joe H. Lowe	Crawford
Paulding	George T. Bagby	Dallas
Peach	Wm. J. Wilson	Ft. Valley
Pickens	A. C. Moore	Jasper
Pierce	L. J. Cason	Blackshear
Pike	M. E. King	Concord
Polk	M. M. Cornelius	Cedartown
Polk	Paul McKelvey	Rockmart
Pulaski	Pete Pettey	Hawkinsville
Putnam	Dallas Veal	Eatonton
Quitman	Joe J. Hurst	Georgetown
Rabun	Paul Green	Clayton
Randolph	J. Mercer Wooten	Shellman
Richmond	R. Lee Chambers	Augusta
Richmond	William W. Holley	Augusta
Richmond	Carl E. Sanders	Augusta
Rockdale	William Dean	Conyers
Schley	B. E. Pelham	Ellaville
Screven	W. Colbert Hawkins	Sylvania
Seminole	R. E. Wheeler	Donalsonville

County	Representative	Post Office
Spalding	Arthur K. Bolton	Griffin
Spalding	Frank P. Lindsey, Jr.	Griffin
Stephens	Frank L. Gross	Toccoa
Stewart	Sam S. Singer	Lumpkin
Sumter	Thad M. Jones	Plains
Sumter	Jack Murr	Americus
Talbot	H. Chris Callier	Talbotton
Taliaferro	Wales T. Flynt	Crawfordville
Tattnall	Tom Kennedy	Manassas
Taylor	Hugh G. Cheek	Butler
Telfair	Cecil E. Brown	Lumber City
Terrell	Steve M. Cocke	Dawson
Thomas	Robt. E. Chastain	Thomasville
Thomas	O. S. Willis	Coolidge
Tift	Wm. T. Bodenhamer	Ty Ty
Tift	Howard Fowler	Tifton
Toombs	M. Ortez Strickland	Vidalia
Towns	Montgomery Wilson	Hiawassee
Treutlen	Hugh Gillis	Soperton
Troup	Frank G. Birdsong	LaGrange
Troup	C. O. Lam	Hogansville
Turner	T. E. Kennedy, Jr.	Ashburn
Twiggs	Claude S. Kitchens	Dry Branch
Union	Jack G. Tarpley	Blairsville
Upson	L. A. Mallory, Jr.	Thomaston
Upson	Johnnie L. Caldwell	Thomaston
Walker	Robert E. Coker	LaFayette
Walker	Albert Campbell	LaFayette
Walton	John Lee Phillips	Monroe
Ware	W. A. Frier	Millwood
Ware	Cleve Mincy	Waycross
Warren	Jack B. Ray	Norwood
Washington	Harvey Roughton	Sandersville
Wayne	Robert L. Harrison	Jesup
Webster	J. Lucius Black	Preston
Wheeler	C. M. Jordan, Jr.	Alamo
White	Franklin F. Truelove	Cleveland
Whitfield	Harlan Houston	Dalton
Whitfield	Harvey G. King, Jr.	Dalton
Wilcox	D. E. Turk	Abbeville
Wilkes	H. G. Garrard	Washington
Wilkinson	A. T. Land	Allentown
Worth	David C. Jones	Sylvester

OFFICERS OF THE STATE SENATE

TERM 1955 - 1956

PRESIDENT

S. ERNEST VANDIVER.....Lieutenant Governor
FRANKLIN COUNTY

G. EVERETT MILLICAN.....President Pro Tem
FULTON COUNTY

GEORGE D. STEWART.....Secretary
FULTON COUNTY

LAMONT SMITH.....Assistant Secretary
TATTNALL COUNTY

OFFICERS OF THE

HOUSE OF REPRESENTATIVES

TERM 1955-56

MARVIN E. MOATE.....Speaker
HANCOCK COUNTY

HAROLD S. WILLINGHAM.....Speaker Pro Tem.
COBB COUNTY

JOE BOONE.....Clerk
WILKINSON COUNTY

JACK GREEN.....Assistant
RABUN COUNTY

Medical Manpower Problems in the United States and Overseas

FRANK B. BERRY, M.D., Washington, D. C.

THE YEARS FOLLOWING World War II have left us with a medical manpower problem totally unlike any previous era in our history, for instead of contracting back into the United States our Armed Forces are still stationed in many other parts of the world. Quite apart from the United States and Alaska, now we have requirements for doctors and dentists all over the world including numerous small island stations and some embassies. To meet this over-all requirement, as well as civilian needs in the United States, there are approximately 221,000 physicians who are graduates of Class A schools, 12,000 aliens licensed to practice in the United States, plus an additional 9,000 osteopaths, of whom approximately 6,500 have taken and passed the full examination in medicine and surgery in 35 of our states and the Territory of Hawaii.

In a recent report, *Mobilization and Health Manpower*, issued by the Health Resources Advisory Committee to the Office of Defense Mobilization, there is the following table. As you will note, the total of 215,000 is 6,000 less than the previous figure, which is the latest I have been able to obtain from the American Medical Association. Also, this table does not include foreign physicians or osteopaths, but for all practical purposes it is as nearly accurate as any I have been able to find.

Whether the total number is 215,000 or 221,000, there are included approximately 50,000 physicians under the age of 51, probably more, who have already served two years in the Armed Forces during or since World War II. Also, those now serving in the Armed Forces are decreasing as the Armed Services approach 2,850,000, the goal announced by the President. For example, on 1 January 1953, there were 13,342 physicians in the military services, and on 1 January 1955 there were 10,749. Just what do

Private practice	139,000
Interns and residents (in non-Federal hospitals) ¹	20,300
Mental and tuberculosis hospital staffs.....	3,000
Medical school faculties ²	5,300
Industrial medicine ²	2,000
State and local health departments	2,000
Public Health Service	1,400
Armed Forces	11,300
Veterans Administration ²	6,000
Insurance and miscellaneous	1,700
Retired and not in practice ³	23,000
Total	215,000

these 10,749 physicians do? First, there are approximately 2,900,000 servicemen and then, in addition, about 2,200,000 dependents, and in various foreign countries 29,000 civilian employees with dependents who look to the military for care, which is a potential load of about 5,000,000 people to be cared for by doctors and dentists in the Armed Forces. I shall not go into the pros and cons for care of dependents, but merely cite the present situation as it exists.

To turn to civilian needs for a moment according to the distribution of physicians by medical service areas, in 1940 there was a population to physicians ratio of 754 to 1; 10 years later this was 735 to one, and in 1953 it was estimated to be 732 to one. According to samplings of Dr. Frank Dickinson, American Medical Association Economist, when considered by medical service areas, in the sparsely settled areas,

1. There are in addition some 5,500 aliens serving on hospital house staffs most of whom are here only for temporary training.

2. Full-time equivalents.

3. This number is estimated as being equal to 2/3 of those over age 65. (See Ciocco, Antonio; Davis, Burnet M.; and Altman, Isadore, Measures of Medical Resources and Requirements, *Medical Care*, Vol. 3, No. 4, November 1943).

Dr. Berry is Assistant Secretary of Defense.

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, May 1-4, 1955.

2,020 physicians serve 4,700,000 people, or there were 2,320 persons per active physician; whereas in the densely populated areas, 80,865 active physicians served 56,000,000 inhabitants, or only 690 persons per active physician. The 72 four-year medical schools in this country are all located in 49 of what Dr. Dickinson calls our 88 "prime-primary" medical service centers, where all the specialties are available. These figures are somewhat confusing, but they illustrate the complexity and difficulty of the problem and the way they may be used to *prove* or *disprove* according to one's desires. I would suggest perhaps that more attention should be paid by the military to making use of these "prime-primary" centers, particularly those with medical schools, for opportunity of refreshment for medical and dental personnel while on duty in these areas. Conversely the medical schools and civilian profession might likewise make further efforts in extending a welcome to medical and dental officers situated near them.

In 1950, 5,553 students graduated from medical school and in 1954, 6,861, but, in the class of 1954, 59 per cent had already served their required time in the Armed Forces so that prior to physical examination only about 2,800 were available for military service. In the classes of 1955 and 1956, on the other hand, although there will probably be about 60 per cent, or 4,100 to 4,300, liable for military service, the needs of the armed services for the two years between July 1, 1955, and July 1, 1957, will be approximately 6,300 officers. You can readily understand, therefore, how low is our reserve pool.

Available Draft Pool

Now what is the procedure of the draft and why is this available pool so shallow? First, the military personnel needs are presented to our office by the Surgeons General of the three Armed Forces. A study is made of these requirements by our office following which they are transmitted to the Health Resources Advisory (Rusk) Committee, which agrees or disagrees. If the latter, a satisfactory compromise is worked out and the final requirements are transmitted to the President. He personally initials the list and sends it to Selective Service, which transmits the needs to the local boards who make the actual call. After the men are called they have the right to appeal, first to their local Advisory Board, then to the State Board, and then centrally to Selective Service, and to the Rusk Committee. Selective Service deals with numbers only and has no concern with specialty needs.

There are several reasons why the supply of doctors and dentists at the present time is not greater than it is. Primarily, the cause goes back to our low birthrate during the 1930's, whereas beginning about 1942 it began to rise sharply and has continued

to rise ever since. The results of this shift are now increasingly evident. We have a large number of infants and children at the first end of life and at the same time, due to increased longevity, a greater number in the older age group at the other end, while in-between we have actually fewer *young* adults to care for them. In the mid 1940's about 100,000 males turned 18 each month, whereas in 1955 this figure approximates 94,000, although from now on there should be a steady increase. Combined with this during the 1940-1950 period, the need for physicians and scientifically trained personnel has grown enormously. Likewise during the past 15 years, the demand for automobiles has increased tremendously, and our aircraft industry has expanded in like manner. Television did not exist in 1940, but consider the work in electronics and also atomic research and development since then. Coincident with these, there has been an ever increasing demand for young adults in all the sciences, professions, and industry without any corresponding increase in supply. In 1940 the government contributed about \$185,000 to the medical schools for medical research, and in 1954 the contribution was \$50,000,000. All of us know what has happened to research not only in our medical schools and hospitals but also in government and in the great chemical and pharmaceutical industries. Thus, simultaneously with our expansion in medicine, there has arisen this increased demand in engineering, physics, chemistry, geology, and other allied biological sciences. Although we are in the planning and development stage for eight new medical schools, still there were only 15,000 applicants for entry into medical schools in the fall of 1954 as opposed to 25,000 in 1948.

The two-year military requirement has added two years for almost all of our young doctors in addition to their already long educational period of four years in a medical school, one year in internship and two to five years of residency before they are free to practice their profession; and more or less coincident with this two-year period of government service there has been an altogether inordinate growth in residencies. For example, one teaching hospital, whose report I occasionally see, records six interns and 32 residents for its surgical service of approximately 120 beds, with an outpatient load of 120,000 total visits each year. In addition to this staff there are as many junior fellows, fellows, assistant visiting surgeons and visiting surgeons. As one talks with the resident staffs of many of our teaching hospitals, we hear the common observation that one or two years could readily be left out of their training without detriment. Perhaps we may hear it said that the resident does not have mature judgment, yet he realizes very well when he is marking or wasting time.

Furthermore, even in many of our better hospitals it is difficult to provide truly adequate training in surgery, for example, over a four year period. The work becomes more and more diluted by two factors, multiplicity of attending surgeons, fellows, and residents and the constant growth of compensation and insurance practice so that there is less and less material available to the staff. Then too, many of our teaching hospitals are not interested in the surgery of trauma, which denies instruction in this most prevalent and important type of surgery. The practices in these hospitals combined with the present tendencies of the boards resemble more and more the guilds and the criteria for a well educated and trained surgeon are measured in time rather than in true accomplishment and valuable apprenticeship. But in that measurement of time very little credit is now given to men serving in some of the hospitals of the Armed Forces, particularly those in the overseas area. Having personally visited well over 50 of them and also having received complaints from various of my former residents, I am sure that a niggardly and shortsighted policy is being followed by some of the boards. Many of the young men in those military hospitals are loaded down with work in their specialties and actually practice more medicine than they would if they were at home. True, they miss the organized staff meetings and the advantages of the larger medical meetings. On the other hand, for the most part they are adequately supervised and are maturing both in judgment and self-assurance, and with their new life and new associations those in overseas assignments especially are adding to their general cultural background. Both our hospitals and the specialty boards should reassess their present policies.

"Whole Man" vs. "Specialist"

This brings up the question of "the whole man" versus "the specialist." Much attention these days is being given to the phrases, "total medical care" and "the whole man," and the increasing amount of discussion along these lines indicates a want in our society. In the program for the Fiftieth Anniversary of the Medical College of Evangelists there is a short article entitled "The Whole Man," which is quite independent of an article of the same title in the Winter Number of the *Yale Review*, by Wallace Stevens, written from a philosophic and entirely non-medical point of view and yet applying as directly to medicine as to any other sphere of life. Mr. Stevens muses over the differences between the whole man and the specialist and their production by and relation to the times and environment in which they live. He suggests that the specialist might be termed an "illiberal bigot" but discards that as altogether too crass and points out that our society today is so

complicated that the need of specialists is really very great. So he finally concludes that the "whole man" may be defined as an "intelligent, educated, and widely experienced individual," whereas the specialist may be considered as an "intelligent, educated, and less widely experienced individual." The specialist bears a similitude to the highly trained technician; we must be extraordinarily careful lest he become the "illiberal bigot." As Mr. Stevens pointed out, the heyday of the "whole man" was perhaps 150 to 200 years ago in a far simpler society, when it was necessary that men become well rounded in knowledge and education, whereas today in our complex civilization far more specialists have developed at the cost of the "whole man." We need both, however, so it is time that we re-assess our values even in this most difficult of epochs.

Perhaps I have departed from the main theme, but all of this interweaves so closely with the availability and proper employment of manpower that in order to understand one we must also consider the other. During the period 1950 to 1954 we did not realize that the supply of doctors for the armed services was limited, but this fall when an approximately accurate count was made of the supply of those who had not been in service since World War II, we were somewhat taken aback to find that the cupboard was nearly empty. Therefore in the winter of 1954, to provide for an inflow of men with partial specialist training as well as young men freshly out of medical schools, with the consent of Selective Service and the Health Resources Advisory Committee, we instituted what is known as our Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program whereby a certain number of young men finishing their internships are deferred each year for residency training and then enter the Armed Forces at the completion of it. We were permitted to defer 300 beginning July 1, 1956. We realize these are too few; the proper figure should be 800 or 900, but this is a start and the best we can do. We hope to increase this number for the 1956 group of interns, but this depends in part upon each of the Armed Forces and in part upon reenactment of the special draft legislation for doctors and dentists, which we requested for two purposes: first, the group available was so small I could not do otherwise than advise the Secretary of Defense this was necessary; and second, through it we might be able to defer a larger number of doctors for training so that at its expiration in 1957 a smooth flow into the armed services would be assured by the regular draft law.

Special Draft Legislation

The special draft legislation is protective as well as selective and contains several provisions of im-

portance to medicine and dentistry that do not exist in the regular draft legislation:

"1. The Doctors Draft Law provides for the establishment of national, state and local medical and dental advisory committees to Selective Service. Such committees protect the needs of professional schools, essential research and other civilian requirements. They afford a means of correlating the essential needs of the faculties of dental and medical schools and of the community itself in relation to those of the Armed Forces, particularly in respect to those individuals not liable under the general provision of the basic draft act.

"2. The special act is more inclusive for young physicians and dentists due to certain dependency provisions in the regular draft law.

"3. The several provisions of the Universal Military Training and Service Act of 1948 do not provide for an orderly input of physicians and dentists on a nationwide basis. There is no assurance that the needs of the military departments for these professional personnel would be met or that they would be in excess to the needs with any specific draft call.

"4. The Doctors Draft Law is presently the only authority for bringing to active duty the young reserve medical and dental officers who sought a commission for the sake of protection under the regular draft law.

5. Expiration of the Doctors Draft Law will result in the loss of the protection afforded by this permissive legislation for call up of dentists, physicians and veterinarians under national emergency circumstances as declared by the President or Congress."

As to numbers, what does this legislation really mean to the various Army Areas? Let us take your own Third Army Area of Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, and Tennessee: In Selective Service special call No. 24, of March 1955, 128 physicians were originally called in the Third Army Area but only two-thirds will ultimately be realized by the Armed Forces. In the First Army Area, consisting of New England, New York, and New Jersey, 286 physicians were called, and yet the county medical society of New York County, consisting of the Island of Manhattan, has a membership of 6,500. You see, therefore, these calls are not exactly depopulating in their numbers.

The Health Resources Advisory Committee and the recommendations of the Medical Task Force of the Hoover Commission suggest that more attention should be given by the services to good intern and residency training and to research, but at the same time they complain that too many doctors are now being taken by the military. How can we equate these

two opposite suggestions? I have tried to ascertain what might be a fair proportion of men assigned to research and find that the answer is extremely difficult. Let us say, perhaps, it should be two per cent.

Interns in the Department of Defense

What of the interns? There are 445 in the Department of Defense hospitals this year: Army 149; Navy 179; and Air Force 117. As to residents, the Department of Defense has authorized 911, but during the year there have only been 675 assigned to these positions for further professional teaching and instruction.

As you well know, these are not the only problems of military medicine. Officers should be assigned for work in military intelligence as it pertains to medicine. We have the very large and important area of preventive medicine closely allied with military intelligence, and this includes many of the things which today we take for granted as we enter into and live in new and various areas all over the world. We need a group well versed in medical administration and military medicine in the field if we are to safeguard the health and lives of our troops and to minimize casualties. In the Navy, for example, there is duty with the Marines, air, ships, surface and submarine, as well as land billets. In the Air Force there are several commands, each with its own specific duties. The Strategic Air Force, as you know, must always be ready to move, and as it moves it must take its medical personnel. And then there is always the pipeline of those going in and coming out, those on leave, those who are ill; the time required for transfers from one station to another. These are the problems of military medicine all over the world.

Medical Care in Alaska

Now what of our care in foreign fields? Alaska: this is a huge submarginal area with climates varying from that similar to the coastal area of Central and Southern British Columbia to the Arctic Regions. It presents many problems of living, particularly in sanitary engineering in the central and northern areas. The population has grown from about 25,000 in 1939 to almost 200,000 today, and our military has increased from a small single station there 15 years ago to a large and far-flung force. Here the Air Force is responsible for all the hospitalization. It has two fine large modern hospitals, one at Fairbanks and the other at Anchorage. The Air Rescue Service is superb, so anybody at any place in Alaska is within two hours pickup. In addition to these large hospitals there are smaller ones in some of the Air and Army posts, and the Navy has its own at Kodiak and Attu. But for all important illnesses or injuries, the flow is to the two larger Air Force hospitals, or in the case of the Navy either to these or to its own large hospital in Bremerton, Washington. Dur-

ing the long months of winter, medicine presents its own peculiar problems in this Arctic climate and psychological problems multiply. We believe it essential that families accompany men on duty in Alaska as far as possible; there complete medical and dental care must be given to dependents as there is a great scarcity of civilians in both professions. As a matter of fact, in the Matanuska Valley the Air Force contributes one of its staff from its nearby hospitals at Anchorage to take over the little Presbyterian hospital on weekends so that the local doctor may have a little time to himself occasionally.

The Far East

You are all well aware of our problems in the Far East. We are scattered throughout the islands in the Pacific as well as in Korea, Japan, and the Philippines. All evacuation of patients from the more distant shores is through Hawaii where we find the Army and the Navy jointly operating Tripler Army Hospital, the only military hospital in the Islands. The Navy controls hospitalization on Guam. These two large modern hospitals receive military patients from all services in the Pacific Islands. As you know, our forces are withdrawing gradually from Korea and Japan so that the requirements are less than formerly. In Japan and Okinawa there are many dependents, which add a considerable load upon our medical services as there are but few native physicians. In addition to looking after our own forces and their dependents and the civilian representatives from other departments of our government, the three services have instituted a moderate Japanese intern program whereby selected Japanese medical graduates may serve as interns in our military hospitals. This has required caution and has been carefully worked out with the Japanese authorities so as not to deprive their own hospitals. In our own institutions the outpatient services are well developed and are operated as well-organized group clinics. From the over-all medical standpoint, also, we should be concerned with nutritional problems in the various native populations as one of the most practical and welcome methods of helping these nations during their reconstruction periods.

In the Philippines there are somewhat similar problems, and moreover the present government is most appreciative of any help and advice we can offer as regards their medical schools. All of these Pacific nations likewise have a voluntary tie with us in the Pan-Pacific Surgical Association, which meets every three years and is in the nature of a symposium for all branches of surgery. The Air Force operates the chief hospital in the Philippines; it is also utilized by the Navy and Army.

Throughout the Far East one of the problems of the moment is, of course, the opium traffic, which

extends all the way from Hong Kong and South-eastern Asia to other Eastern ports wherever there are groups in station or in transit. As we review the whole opium question we must consider two facts: first, the East has never regarded opium itself in the same light as we have; second, we now have a Communist desire for U. S. dollars and, of course, opium traffic provides an easy means to this end. The Japanese Government is cooperating extremely well with our own provost and medical departments so that in this country there is a keen awareness of the needs for control, and constant vigil is maintained through our medical and criminal investigational laboratories. In conjunction with the Japanese, we have developed exact urine tests for minute quantities of these various alkaloids.

Europe and the Middle East

Let us turn briefly now to Europe and the Middle East. In England the Air Force is the responsible hospitalization agent. On the Continent both the Air Force and the Army provide major hospitalization, and in North Africa and throughout the Middle East the Navy and Air Force bear the responsibility. In England and Europe it is relatively easy to help our own personnel by part time employment of foreign nationals, particularly in England and Germany. Dr. Hilton S. Read, with the aid of the Ventnor Foundation of which he is Executive Director, has brought over carefully selected graduates of German medical schools to this country for internship during the past five or six years. For example, during the last year 64 such graduates were serving in hospitals in this country. These physicians return to Germany and improve understanding between our two countries, and at the same time they afford a pool available to the Army and Air Force for assistance in the care of our own nationals in Germany. In France the condition is less desirable because of scarcity of housing and the inflation of the franc. Throughout this whole area and extending throughout North Africa and the Middle East there are many medical installations to care for our own soldiers, sailors, airmen, and their dependents, and our numerous civilian groups who are working primarily for the Department of State, Department of Defense, and Foreign Operations Administration.

You can well understand, therefore, how large is our task and how manifold its ramifications. That we do it as well as we do, with a change of about two-thirds of our personnel at two-year intervals, is itself a remarkable feat. We receive a steady stream of criticism, both favorable and unfavorable, all of which we are delighted to have for only out of such criticism, we believe, will come truly constructive progress.

Department of Defense

Scout Film of the Abdomen in Acute Appendicitis

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IT IS GENERALLY ACCEPTED that the diagnosis of acute appendicitis is the clinician's problem. There are cases, however, in which the clinical and laboratory findings are somewhat vague and obscure, and the diagnosis of appendicitis difficult. Many surgeons and clinicians are aware of this difficulty especially when it is realized that pain and tenderness can frequently be experienced in the right lower quadrant in about 10 per cent of normal individuals¹ and in distended colon from increased intracolonic pressure.⁷

It is in the vague and uncertain group that a scout film of the abdomen becomes a valuable adjunct in arriving at a proper diagnosis. Certain findings on the film when correlated with the history, physical and laboratory findings, lead to correct diagnosis in a high percentage of questionable cases. Frimann-Dahl,² in whose clinic the majority of appendicitis cases are examined radiologically, states in part that "roentgen examination in many cases may contribute decisively to the diagnosis." Steinert et al³ reported a series of 104 cases in which 80 showed X-ray findings deviating from normal; of these, 52 cases (50 per cent) showed findings consistent with appendicitis.

The findings associated with acute appendicitis on X-ray film are minimal when compared with abdominal conditions such as obstruction, ruptured ulcer or diverticulum, pancreatitis, cholecystitis, and others.

In our hospital we do not use the X-ray examination in all cases of acute appendicitis. It is used only in those cases that are inconclusive or indefinite from a clinical point of view.

In the past six years we have had referred to the X-ray department 26 cases of intra-abdominal pathology which were suspected of being appendicitis. The clinical findings on these cases were not too definite. On some the history and physical were inconclusive, while in others the laboratory findings consisting of low blood count could not be relied upon. Many of the patients had a previous history of similar attacks, while others gave a history of

ulcers, gallbladder disease, renal stones, and vague abdominal discomforts of questionable etiology.

Of the 26 cases referred to the X-ray department the X-ray findings were consistent with pathology in the area of the appendix in 24. Two cases showed negative X-ray findings but, because of positive clinical and laboratory findings, were operated on, and a normal appendix was found in each case. One case showed positive X-ray findings, but at operation a negative appendix was found. Another case of appendicitis was in a patient with pneumonia. In this case it was difficult clinically to ascertain whether the findings were actually due to appendicitis or pathology within the lungs.

Operation was not performed on four of the 26 cases. These four cases were treated conservatively and discharged from the hospital improved. The four non-operated cases plus the one case of positive X-ray findings, but normal appendix at operation, gives a total of five cases of missed diagnosis. The remaining cases were all proved surgically and

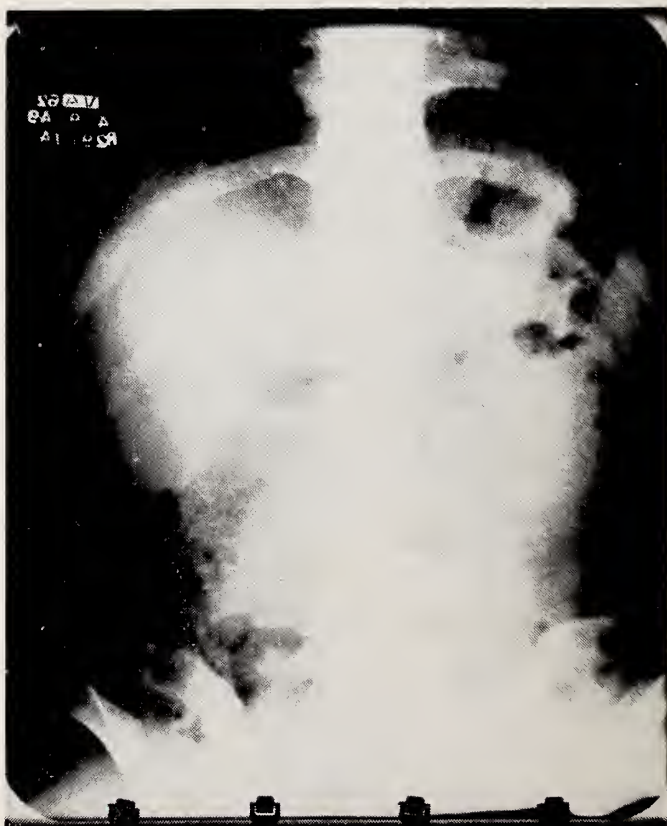


Figure 1

Note "hair-pin" loops of terminal ileum distended with gas. Gas and fluid are also noted in the cecum and ascending colon.

Presented before the Section on Radiology, 105th Annual Session, Medical Association of Georgia, May 2, 1955.

This paper was reviewed in the Veterans Administration and is published with the approval of the Chief Medical Director. The statements and conclusions published by the author are his own and do not reflect the opinion or policy of the Veterans Administration.

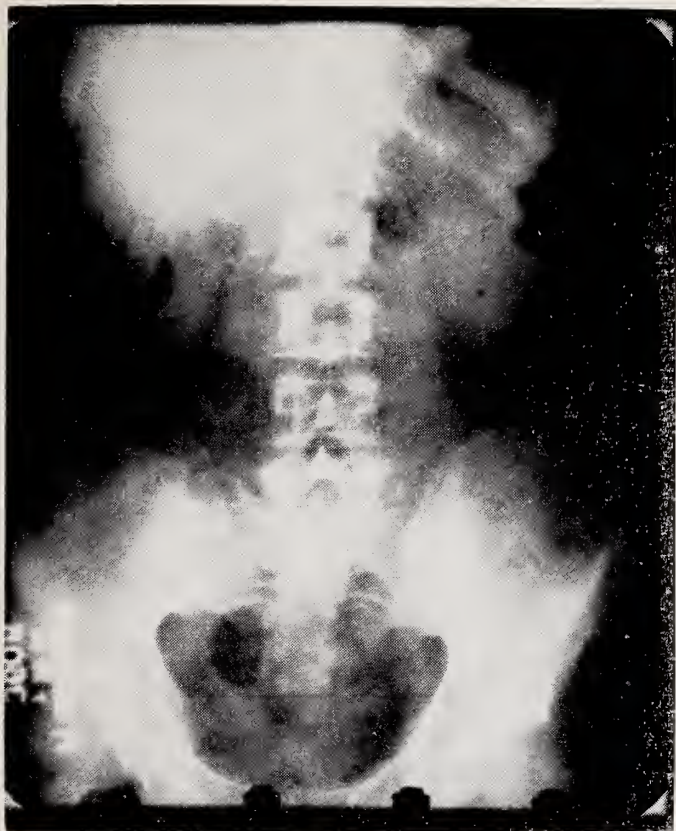


Figure 2

A distended loop of terminal ileum with some indentation of the cecum. Fluid is present and the psoas shadow is obscured.

pathologically to contain inflammatory changes in and around the appendix, for an average of approximately 80 per cent correct roentgen diagnosis.

Case 1

Number 16 366, admitted 4-9-49, male, white, age 32, cramping pain in abdomen, mild, 24 hours duration, no localization. Physical Examination: temperature 99°, pulse 100. Tenderness in right lower quadrant, moderate rigidity, generalized. Laboratory Findings: white blood count 12,000.

Roentgen Findings: scout film of the abdomen reveals several short "hair-pin" distended loops of terminal ileum in the vicinity of the ileocecal valve with small amount of fluid. Gas and fluid are also present in the ascending colon and cecum (Figure 1). Findings are consistent with pathology in the vicinity of the appendix.

Pathology: appendicitis, subacute.

Case 2

Number 25 722, admitted 7-30-53, male, white, age 43, pain right lower abdomen, one day duration, vomited one time prior to admission. Physical Examination: temperature 99°, Pulse 120. Slight muscle spasm, point tenderness in right lower quadrant. Laboratory Findings: white blood count 12,000.

Roentgen Findings: scout film of the abdomen reveals a distended loop of terminal ileum in the vicinity of the ileo-cecal valve with slight indentation of the cecum and compression of the ascending colon. Some fluid in the distended bowel with obscuring of the psoas (Figure 2). Findings are consistent with pathology in the vicinity of the appendix.

Pathology: appendicitis, acute.

Case 3

Number 25 437, admitted 6-10-53, Negro, male, age 29, vague abdominal pain, four days duration, no nausea or vomiting. Physical Examination: temperature 100°, Pulse 60. Some rigidity in right lower quadrant, no rectal tenderness. Laboratory Findings: white blood count 10,500.

Roentgen Findings: scout film of the abdomen reveals a distended loop of terminal ileum in the vicinity of the ileo-cecal valve with suggestive soft tissue mass in the right lower quadrant, some compression of the distended cecum and ascending colon (Figure 3). Findings are consistent with pathology in the vicinity of the appendix.

Pathology: appendicitis, acute.

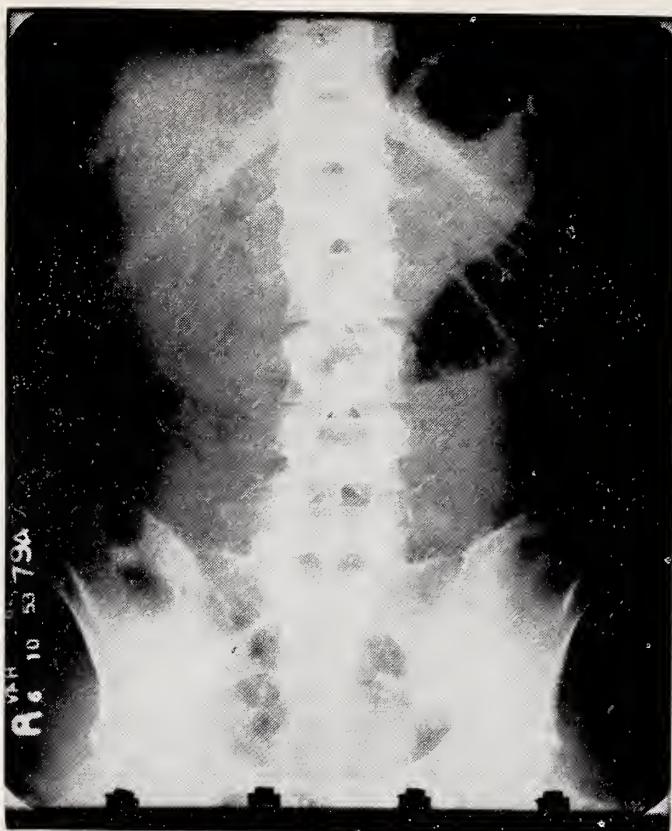


Figure 3

Note distended loop of terminal ileum extending across the sacro-iliac joint on the right side. Gas and fluid are also noted in the cecum and ascending colon. A suggestive soft tissue mass with indentation of the cecum and obscuring of the psoas shadow.

Case 4

Number 28 845, admitted 4-2-54, Negro, male, age 28, pain lower abdomen, three days duration, sharp, intermittent. No nausea or vomiting. Physical Examination: temperature 101°, pulse 84. Pain on palpation in region of McBurney's point with



Figure 4

Note gas in terminal ileum and ascending colon with fluid. A soft tissue mass is demonstrable obscuring the psoas shadow and compressing the extra peritoneal fatty layer.

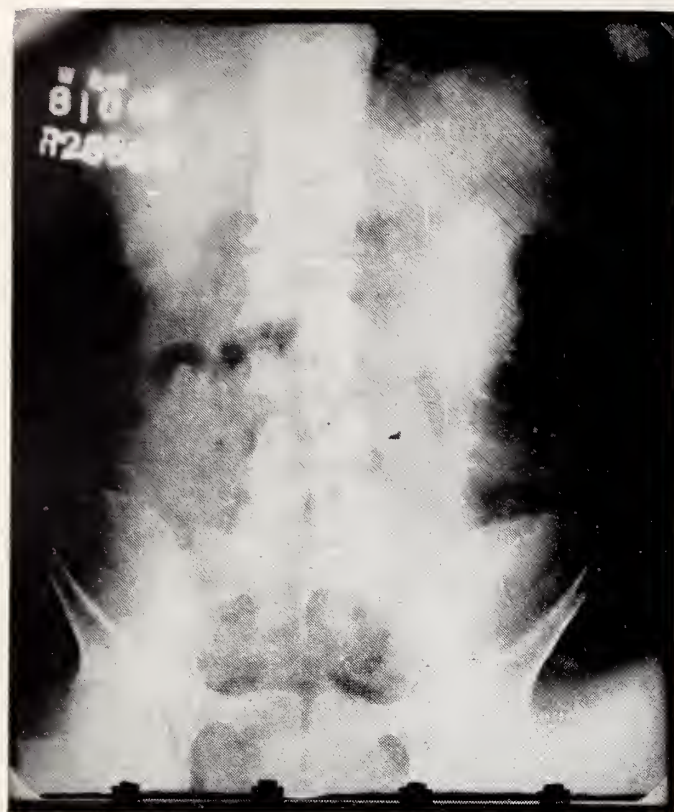


Figure 5

Note well-circumscribed soft tissue mass right lower quadrant. Several loops of distended terminal ileum and colon with fluid. Psoas shadow is obscured.

well marked rebound tenderness. Some voluntary muscle guarding in right lower quadrant. Rectal essentially normal. Laboratory Findings: white blood count 14,500.

Roentgen Findings: scout film of the abdomen reveals several loops of terminal ileum to be distended with obliteration of the psoas shadow and fatty layer. Some evidence of fluid and gas in the cecum and ascending colon noted (Figure 4). Findings are consistent with pathology in the vicinity of the appendix.

Pathology: appendicitis, acute.

Case 5

Number 16 880, admitted 8-10-49, male, white, age 58, pain right abdomen, moderate, one day duration. Some nausea and vomiting. Physical Findings: temperature 99.8°, pulse 94. Pain on palpation in right lower quadrant, some generalized abdominal rigidity and guarding. Rectal essentially normal. Laboratory Findings: white blood count 11,000. Urinalysis one plus sugar.

Roentgen Findings: scout film of the abdomen reveals a soft tissue mass, well circumscribed, in the right lower abdomen with indentation of the cecum and ascending colon. Some fluid is noted within the distended loops (Figure 5). Findings are consistent with pathology in the vicinity of the appendix.

Surgery: appendectomy was performed and large amount of sero-purulent exudate was found in the abdominal cavity in the vicinity of the appendix, which was ruptured.

Pathology: appendix, acute, gangrenous (perforated).

Case 6

Number 28 439, admitted 6-23-54, male, white, age 31, vague abdominal pain, three days duration, increased in severity last 24 hours. Some nausea, no vomiting. Physical Findings: temperature 101.8°, pulse 80. Some generalized rigidity of abdomen with guarding, moderate rebound tenderness over entire abdomen, more pronounced in right lower quadrant. Laboratory Findings: white blood count 8,000.

Roentgen Findings: scout film of the abdomen revealed a distended loop of terminal ileum in the vicinity of the ileo-cecal valve. Arborizing radiations are noted along the concave portion of the distended loop. Some gas is also present in the cecum and ascending colon. Psoas shadow is obscured (Figure 6). Findings are consistent with pathology in the vicinity of the appendix.

Surgery: fluid was found in the peritoneal cavity, appendix perforated.

Pathology: appendix, acute (perforated).

Findings

The following are the most common findings and the number of cases in which they occurred:

Gas:

Ileum	24
Cecum	22
Ascending Colon	22

Fluid:

Ileum	19
Cecum	22
Ascending Colon	22

Gas Fluid Levels: 22

Soft Tissue Mass: 20

Obscuring of

Psoas Shadow: 14

Obscuring of

Flank Stripe: 11

Lumbar Scoliosis: 8

(a) Muscle Spasm

(b) Narrowing of distance between thoracic cage and crest of ileum.

Indentation:

Gas filled cecum 5

Gas and fluid are the most common findings and

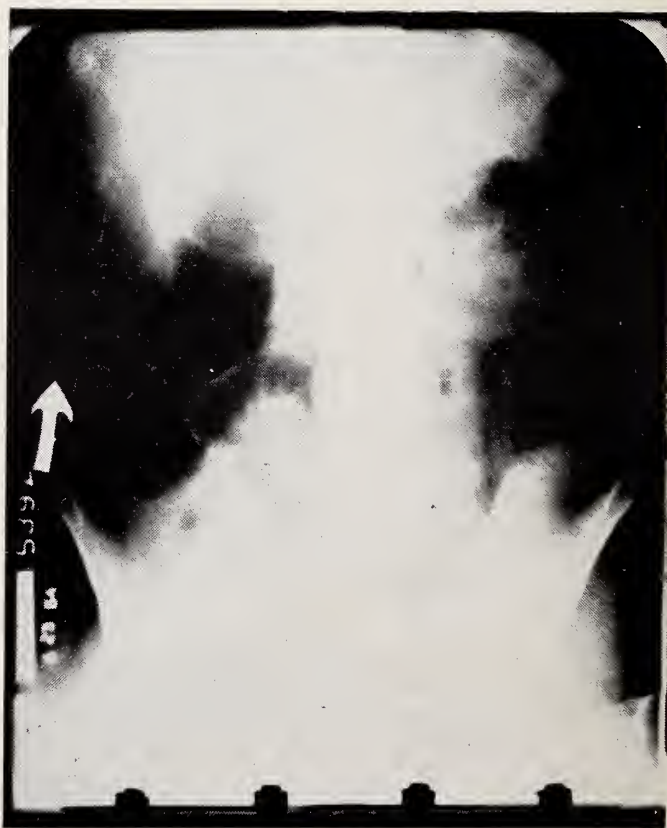


Figure 6

Note distended loop of terminal ileum with gas in cecum and ascending colon with fluid. Soft tissue mass is present with arborizing radiations in the concavity of the distended ileum as result of intraperitoneal fluid. Psoas is obscured.

may be in the terminal ileum, cecum, and/or the ascending colon, or in all three segments at the same time. It is usually associated with fluid and is demonstrated by gas-fluid levels. We have been able to ascertain this finding in most of our cases by taking a scout film of the abdomen either in antero-posterior or postero-anterior view. The author prefers the former because of: (1) greater contrast and definitiveness of the soft tissues in the right lower abdomen, and (2) absence of obscuring of the field by distorted overlying sacrum. In this view the soft tissue mass, as a rule, is not as clear cut as it is on postero-anterior film, but it usually can be made out on a film of good quality. It is preferable, however, for a greater degree of accuracy, routinely, in addition to the postero-anterior and antero-posterior films of the abdomen, to also take an upright and a lateral decubitus. These two films will always show the presence or absence of gas-fluid levels.

The presence of gas in the distended intestinal loops is probably due to peritoneal irritation with atony and paralysis as result of inflammatory changes. Brown¹ believes that paralytic ileus is due to splanchnic paralysis or peritoneal irritation. The air is probably atmospheric, either swallowed⁶ or respired.³ Some of the gas may have its origin in the cecum and ascending colon, and may gain access to the ileum through the relaxed Sphincter of Bouhin.

The soft tissue mass, which in our series was noted in 20 cases, is usually the result of peritoneal irritation, omental overlap, edema, fluid, and congestion in and around the involved appendix.

Obscuring of the psoas was noted in 14 cases. This finding is more pronounced in the postero-anterior view because of the anatomical position of the soft tissue mass which, in this position, lies in front of the psoas muscle.

The flank stripe, or extra peritoneal fatty layer, was obscured in 11 cases. It is an important sign and should be looked for carefully. It usually consists of indentation, narrowing or obscuring of the extra peritoneal fatty layer.

Although lumbar scoliosis is mentioned as a finding of some significance by Frimann-Dahl² and Steinert and his co-workers,⁵ we have not found this sign to be too reliable since many patients have some degree of normal rotoscoliotic curvature of the lumbar spine.

The narrowed distance between the crest of the ileum and the thoracic cage on the involved side and muscle spasm are also difficult to evaluate at times on X-ray film.

Indentation of the gas-fluid filled cecum was noted in five cases. This finding was noted particularly in ruptured and severe acute appendicitis where considerable soft tissue reaction was taking place.

The absence of these signs on roentgen films does not necessarily rule out appendicitis. In cases with inconclusive physical and laboratory findings, however, this sign needs to be given due consideration as demonstrated in the two cases that showed negative roentgen findings, but because of positive clinical and laboratory findings were operated on and a normal appendix was found in each case.

The duration of the symptoms in our series of cases ranged from a few hours to several days, and the roentgen findings were noted in all of them. The time of onset and duration of symptoms apparently had little or no effect upon the localization of the gas in the terminal ileum. The roentgen findings are not to be depended upon if an enema has been given prior to the taking of the film because of the retention of air and fluid in the cecum and ascending colon.

Summary

1. Scout film of the abdomen was studied in 26 cases of suspected or questionable appendicitis. Positive findings were noted in 24 cases. One of these cases at operation showed a normal appendix. Four were not operated on, and two cases which showed negative X-ray findings, but suspected positive clinical findings were found to be negative at operation. Approximately 80 per cent correct diagnosis by X-ray was obtained.

2. The examination, for obvious reasons, is only recommended in questionable and inconclusive cases from clinical point of view.

3. The most common and persistent finding consists of gas and fluid in the terminal ileum, cecum, and ascending colon.

4. Antero-posterior view is preferable because of the greater detail and absence of distorted sacral superimposition.

5. Enema should not be administered to the patient prior to the taking of the X-ray film.

Veterans Administration Hospital

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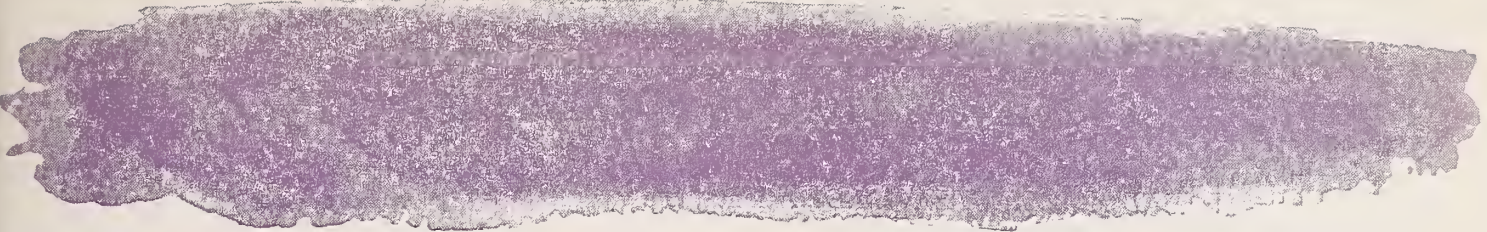
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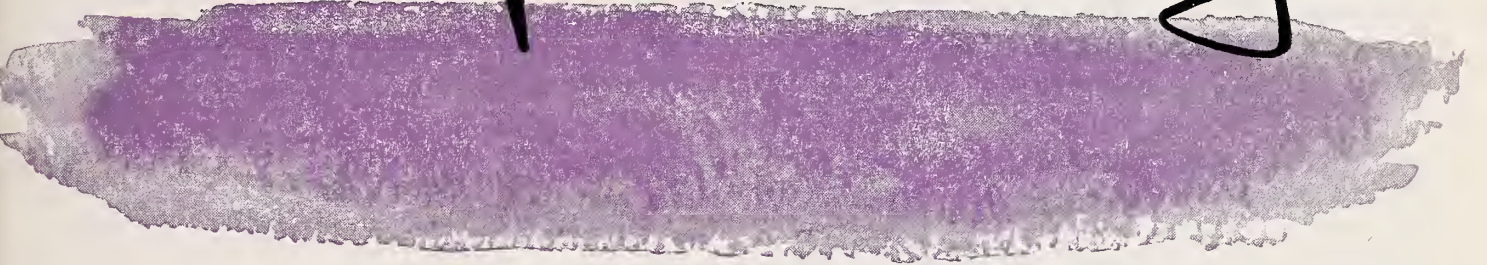
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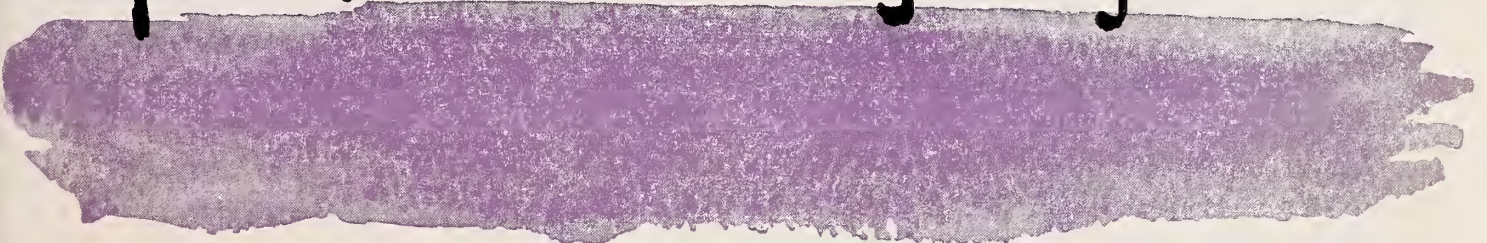




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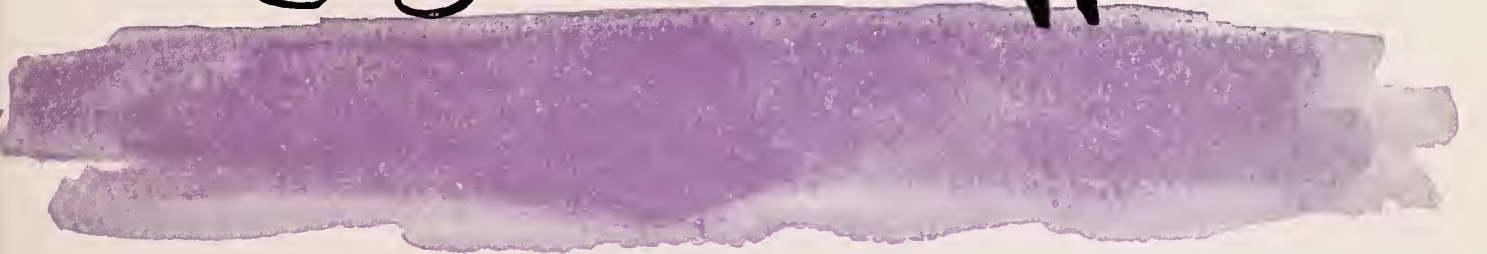
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negligible side effects



The First Physician Comes to Georgia

ALFRED A. WEINSTEIN, M.D., Atlanta, Ga.

THE BRITISH CROWN in 1732 granted 10,000 pounds sterling to "twenty-one trustees, noblemen, and gentlemen of Great Britain." They were charged with establishing a colony named Georgia, for King George II; it was the last British colony to be founded on American soil.

The medical history of Georgia also began in England in November 1732 at Palace Court, London. A certain Mr. Cox, surgeon, at a meeting of the trustees, offered his professional services to the immigrants for one year "without fee or reward." His only stipulation was that the colonists build him a house and till his 50 acre-land-grant, free. Apparently this offer was accepted, for the trustees resolved to buy him a set of instruments and a chest of medicine. It is probable he died in England before departing. If he did land in Georgia, he must have died immediately after his arrival, for history loses all trace of him except for the record of a grant of land "Garden No. 52" being made in July 1733 to "Frances, widow of Dr. Wm. Cox."

The passenger lists on the ship "Ann" bound from Gravesend, England, November 17, 1732, with 114 immigrants on board (35 families) reveals the name of one physician, Noble Jones. Captain Jones, as he preferred to be called though he had received an M.D. degree, had neither time nor inclination to practice his profession. A friend of Oglethorpe, soon after his arrival in Savannah in February 1733, he was assigned at his request to "the command of a scout guardboat and company of marines."

The original colonists, therefore, had absolutely no trained medical personnel.

Medical help for a colony of members of the Church of England was instituted, providentially enough, by the Catholic Church. Briefly, the Spanish Inquisition began in the reign of Queen Isabella in 1492. Infidels, Jews, Moslems, and non-believers were given the choice of compulsory conversion to Catholic Christianity or destruction by fire or torture. Those who could, fled to more friendly lands in Europe, the West Indies, and South America. Those who were trapped in Spain accepted death or conversion. Many of these Jewish converts, or Maranos as they were called, followed their religion secretly, as did the early Christians in Roman days. Among these crypto-Jews living in Lisbon, Portugal, in 1732,

was Dr. Samuel Ribiero Nunez. Member of a distinguished family, this cultured physician, then about 50 years old, had an extensive practice in that city. He and his mother, his wife Rebecca, two sons Daniel and Moses, his daughter Zipra, and servant Shem Noah, were apprehended by the "familiaris of the Inquisition," priestly spies, while "seeking the Lord according to their prohibited faith" and were thrown into jail. There they were subjected to slow torture and would soon have perished except for the intervention of the Grand Inquisitor himself, a long-time patient of the good doctor. The Catholic ecclesiastical council reluctantly agreed to release Dr. Nunez (so that he could treat the Grand Inquisitor) making proviso for two officials of the Inquisition to live with that family "to prevent another relapse into Judaism."

On the banks of the Tagus, Dr. Nunez had a mansion in which he frequently entertained the first families of Lisbon and visiting foreigners. One day, the captain of a British brigantine anchored in the river was a guest in his home. He invited the Nunez family (accompanied by their Inquisition Keepers) to visit his ship. As soon as they were on board, anchor was weighed and the sails unfurled; the ship put out to sea and arrived safely in London.

The Jews in London, who had been contributing liberally to provide homes in the new colony of Georgia for impoverished Christians, found it logical to provide transport for their own poor. They chartered and sent two boatloads totalling 90 Jews to Savannah in one year. On the first boat, with 40 others, was Dr. Nunez and family who arrived July 11, 1733, six months after Oglethorpe.

His arrival was more than providential because an uncontrolled epidemic of "bloody flux" and "malignant fever" was raging. Of the original 114 colonists, 29 had died, while the survivors scarcely had the strength to bury the dead.

The remedies Dr. Nunez had available were limited in amount and were soon exhausted. His training in botany permitted him to make use of indigenous plants with great success. He made extensive use of laudanum to control the "bloody flux," and lemon extract to treat the scurvy which appeared in these debilitated patients. He used ipecacuanha empirically, without knowing that it had a specific

action on the amoeba histolytica. With infusions of cinchona bark he treated the “malignant fevers,” considered to originate from the evil night miasmas of the marshes (malaria—mal aria—bad air). When the supply of this medicine was exhausted he used as a substitute the bark of white-oak, red-oak, and dogwood. He used tartar emetic to produce vomiting in the patients with food poisoning, jimson weed smoked in a pipe for asthma, and sassafras root tea as a “purifier of blood.”

The epidemic subsided. The colonists returned to their work. Dr. Nunez built his home and settled his family. Oglethorpe sent a report of the help of this first active practitioner of medicine in Georgia to the Trustees of the Colony. These gentlemen requested Oglethorpe to offer to pay that humane physician for medical services he had rendered to the colonists without charge. The accounts of the colony do not indicate that payment was ever made.

Dr. Nunez had to rely on his own resources, the drugs procured from England, and the plants and herbs native to the region. He received help from the Jew, Abraham de Lyon, who had come with him in the original contingent of July 1733. De Lyon was a practical farmer who grew successfully peas, grain, and rice. He was also a viniculturist by training from Portugal, and succeeded in raising “beautiful almost transparent grapes.” He laid out a 10-acre tract as a botanical garden, and introduced foreign plants with valuable medical properties.

Two years later Dr. Nunez met John Wesley, who arrived in Savannah with a commission from the trustees appointing him to the office of “priest of the Church of England” to the Savannah mission.

Said John Wesley, the Methodist, “I began learning Spanish in order to converse with my Jewish parishioners, some of whom seem nearer the mind that was in Christ than many of those who call him Lord.” He exhibited great interest in Dr. Nunez’s medical practice, and discussed with him the conduct and care of his patients.

The colony of Georgia increased in size and steadily became more cosmopolitan. It became a little New York of Britons, Jews, Germans, Irish, Salzburghers, Moravians, Scottish Highlanders, and a few Catholics. By 1735 there were more non-English speaking settlers than there were Britons. Dr. Sam Nunez’s broad culture served a great purpose at this time. He was a linguist who could speak

five foreign tongues. It was therefore most consoling to the newcomers to be reassured and treated by one who spoke their native language.

The Trustees in England showed their interest in his work and sent “casks of wine and packets of drugs” to be used for the colonists. Among these were “two barrels containing twenty-three deer skins’ weight of Bears oil” and several parcels of “sea pod, snake root, sassafras, china root, sumac, and contrayerva.” Dr. Nunez opened the first pharmacy in Georgia to compound his medications from these imported and native-grown herbs.

From 1735 to 1740, Dr. Nunez watched with apprehension while Oglethorpe made a series of aggressive moves toward Spanish Florida. First came the fortification of St. Simons Island and then the establishment of the Fort in Frederica. Finally came the preparations for the disastrous attack upon and unsuccessful siege of the Spanish Fort at St. Augustine.

News arrived in Savannah that the Spanish were preparing to invade Georgia. To Dr. Nunez and his family the Inquisition was still a reality. He remembered prison hunger. His aunt, Abigail de Lyon, who had recently died in Savannah, carried to her grave the marks of the ropes which had tied her to a rack in a Portuguese dungeon. Dr. Sam had given up an assured position of wealth and affluence in Lisbon to practice the faith of his Jewish forefathers. He preferred to continue to live as a Jew. And he had no desire to expose his family and himself to the uncertain mercy of Spanish Inquisitors after having risked everything to escape from the Portuguese Inquisition. He knew that he and his family would be convicted as heretics for “seeking God through Judaism” and then burned at the stake if they were captured.

Dr. Sam paid his last visit to his patients, traveling by foot, horse, and rowboat. He again assembled his family: his mother, his wife Rebecca, his two sons Daniel and Moses, his daughter Zipra, and his personal servant Shem Noah, and set sail for Charleston, South Carolina. The Portuguese Inquisition had been responsible for the arrival in Georgia of Dr. Nunez, gentleman of education, humane and skillful physician, the first active practitioner of medicine in this colony. The threat of the Spanish Inquisition was responsible for his departure, after he had sustained the colonists for seven long and arduous years.

663 West Peachtree St., N.E.

Did You Know?

The human heart is rated as having 1/240th of one horsepower and it pumps between nine and 10

tons of blood through the body every twenty-four hours.

Abacterial Pyuria

RAFE BANKS, JR., M.D., Gainesville, Ga.

TODAY THE ETIOLOGY, diagnosis, and treatment of most cases of cystitis are fairly routine. Bacteriological investigation has clarified the classification of most of the offending organisms which commonly produce inflammation of the bladder. Within this realm of knowledge there remains one, abacterial pyuria, which still defies an exact etiological classification. According to Moore,⁴ Fal-tin in 1909 first suggested this condition. It was periodically mentioned in the European literature for many years thereafter. It was not until 1933 that Wildbolz⁵ in an address before the French Urological Conference definitely established its symptomatology and its successful treatment with the arsenicals. He noted that its etiology was obscure, and it has remained so to this date. Today the physician in general practice successfully treats many of the simple infections of the urinary tract. The urologist inherits those cases which do not respond to the usual regimen of antibiotics. The purpose of this paper is to focus attention on this urinary tract infection of unknown etiology which is most resistant to the usual treatment of antibiotics but which responds most dramatically to the arsenicals.

Etiology

The etiology of abacterial pyuria is unknown. Smears and cultures are negative for bacteria. Toxins have been considered but ruled out. Syphilis or other spirochetal types have been suggested, but no spirochetes have ever been demonstrated, and blood compliment-fixation tests are consistently negative. Fungi have never been demonstrated. Tuberculosis has been consistently eliminated by thorough study. By the process of elimination, the possibility of virus infection remains. No definite proof has been offered for this, but it seems to be the most likely possibility.

Pathology

The pathology of this condition is an inflammation limited to the mucosa and submucosa of the urinary tract. It is most frequently located in the bladder but at times may involve the mucosa from the kidneys to the external urinary meatus. The parenchyma of the kidney is uninvolved. The mucosa is hyperemic, thickened and edematous. Frequently a fibrinous exudate is seen. There is a submucosal infiltration of eosinophils, lymphocytes, and plasma cells. Occasionally submucosal follicles are observed.

No bacteria can be demonstrated by special stains.

The pathogenesis of this condition is unknown.

Symptomatology

The symptomatology is usually quite characteristic. It most commonly occurs in young males between the ages of 20 and 30. Yet it may also occur in females of any age. The onset is usually quite sudden and may be preceded by a very slight urethral discharge. Marked frequency, urgency, strangury, and gross hematuria then appear. There is marked suprapubic pain. Pain in the flanks is present if the ureters are obstructed by bullous edema in the bladder or if the mucosa of the upper tracts is involved. Fever is either absent or of a low grade intensity. Systemic reactions are minimal. They are mainly those produced by a marked loss of sleep secondary to pain and frequency of urination. The physical examination is essentially negative except for the suprapubic pain and the occasional tenderness in both flanks. Examination of urine reveals many pus cells, but no organisms can be demonstrated on smear or culture. Laboratory tests are negative for tuberculosis. Cystoscopic examination always has to be done under anesthesia due to the extreme degree of pain. The mucosa is red and covered with patches of mucous exudate. There are areas of hemorrhage, and the mucosa bleeds easily upon touch. Frequently the mucosa is inflamed so extensively that the ureteral orifices cannot be located. The capacity of the bladder is extremely small.

The x-ray findings are variable. The upper urinary tracts may be entirely normal or one side may show early hydroureter and hydronephrosis, or both sides may show this. On cystogram a small contracted bladder is seen.

Diagnosis

The diagnosis is made on the basis of exclusion of bacterial cystitis. Tuberculosis must be ruled out first. On gram stain no organisms are found and all cultures are negative. The differential diagnosis is usually that of tuberculosis, bacterial cystitis, tumor of the bladder, or interstitial cystitis.

Treatment

Dramatic results in the treatment of this condition may be achieved by injecting Neoarsphenamine² 0.4-0.6 grams intravenously every two days for four

doses. Frequently after the first injection the patient is noticeably more comfortable, and the frequency and urgency diminish. The use of the various antibiotics and sulfa drugs usually meet with no success.

Prognosis is usually good. Fortunately a high percentage of these cases are cured quite dramatically with one course of Neoarsphenamine. A small percentage of cases tend to relapse and recur. Aberhart¹ described four cases which did not respond to arsenicals and in whom he did uretero-intestinal transplants.

Landers and Ranson³ and other authors have suggested the possible relationship of abacterial pyuria to Reiter's Syndrome. They state abacterial pyuria is simply one isolated manifestation of mucosal involvement of the urinary tract; whereas, Reiter's Syndrome includes mucosal involvement of the urethra and the conjunctiva and the mucous lining of joints.

CASE REPORT

A 51 year old carpenter was admitted to the Hall County Hospital with a chief complaint of severe frequency and urgency of one week. Prior to one week ago he had never had any difficulty with his urinary tract. Beginning at that time he had the sudden onset of burning, frequency, urgency, and terminal hematuria. He noticed no urethral discharge. This was so excruciatingly painful and the frequency of urination was so great that for a whole week he had been almost without sleep. He had been hospitalized at another hospital for six days and given many antibiotics without any relief.

On physical examination he was a rather thin, tired, obviously ill man appearing chronically ill. His temperature was 99.8 F. Blood pressure 140/80, pulse 80, respiration 20. He had no other marked physical findings except pain over his bladder on deep pressure. He had slight right flank pain. Rectal examination revealed a benign prostate of approximately 15 grams in weight which was smooth and symmetrical.

Gram stain of urine was negative for any organisms. Urine was negative for sugar, had a trace of albumin, specific gravity 1.014, ph. 5.5, and on microscopic examination was loaded with white and red blood cells. Urine culture was reported as "no growth." Acid-fast stains for tuberculosis were negative and cultures of the urine for tuberculosis were also reported as negative.

Intravenous Urography revealed prompt bilateral appearance of the contrast medium but with some slight dilatation of the right ureter and right calyceal system. The excretion cystogram revealed a small contracted bladder with evidence of negative filling defects which on cystoscopy were seen to be large areas of bullous edema. A retrograde pyelogram was attempted, but the ureteral orifices could not be located due to the marked edema of the bladder. The mucosa of the bladder bled quite easily; it was bullous in appearance and markedly hyperemic. He was given 0.4 grams of Neoarsphenamine intravenously every two days for four doses. Following the first injection he immediately improved. At the end of two days he was essentially asymptomatic and his urine showed only a rare white blood cell.

Attempts have been made to get follow-up repeat urograms on this man, but he states he is feeling so good he sees no reason for any further treatment.

Summary

Abacterial pyuria is an inflammatory condition of the mucosal lining of the urinary tract. Its etiology and pathogenesis are unknown. It most frequently affects young men, but cases have been recorded in both sexes of almost any age. Its onset is quite sudden and is accompanied by marked urgency, frequency, strangury, and terminal hematuria. Cystoscopy reveals a markedly inflamed bladder, and intravenous urography may show a normal upper urinary tract or one with varying degrees of hydronephrosis. The diagnosis is based on a negative gram stain, negative bacterial cultures, and negative cultures for tuberculosis and is confirmed by a therapeutic response to the intravenous use of Neoarsphenamine. Occasionally, there are cases which relapse and then pursue a chronic course.

111 North Main Street

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"What's Up With Our Medical Schools?"

RECORD ACHIEVEMENTS by our nation's medical schools during the past year are emphatically pointed up in an attractive new 12-page pamphlet currently in production by the American Medical Association. The pamphlet entitled, "What's Up With Our Medical Schools?" discusses four main phases of medical education in which the 80 approved medical schools in the country now are surpassing all previous records.

These areas are: (1) medical school enrollments; (2) number of medical school graduates; (3) medical school finances, and (4) medical school facilities.

Particularly suitable for distribution in doctors' reception rooms, through schools and at health fairs, quantities of the pamphlet will be available after July 1 from state medical societies or the AMA's Public Relations Department.

The Need for a Hospital Care Study Commission in Georgia

HENRY C. PEPPER, Ph.D., Atlanta, Ga.

THERE IS AN increasing need and demand for more adequate provisions for the hospitalization, medical care, and treatment of the indigent sick in Georgia. Society has generally accepted the obligation and the responsibilities of providing for the sick poor either through charitable or governmental agencies. The American Medical Association, the American Hospital Association, and state level components of these associations have recognized the desirability and necessity of encouraging charitable efforts and obligations of governmental units with respect to hospital and medical services to persons with low incomes. Studies have been made or statewide indigent care programs are now in operation in nearly all southern states except Georgia.

In Georgia, various committees of the Medical Association of Georgia, the Georgia Hospital Association of Hospital Governing Boards, the Georgia State Nursing Association, The Joint Commission for the Improvement of Patient Care, the Better Health Council of Georgia, the Georgia Pediatric Society, the Georgia Academy of General Practice, the Georgia State Obstetrical and Gynecology Society, the Georgia Department of Public Health, the two medical schools, and numerous other related organizations in the state have become concerned over the problem. Plans are now underway to submit to the Governor and the General Assembly of Georgia, a request for the creation of a study commission on the hospital care of the indigent in Georgia. Those familiar with the problem in Georgia recognize the many complicated factors other than the necessary funds to pay the costs of such a program. For example, the study group should investigate the following factors related to problem:

(1) The extent of state, county, city, and philanthropic aid for the hospitalization of indigents.

(2) The extent to which city, county, and state lines complicate the problem of indigent care; how citizens in counties without medical and hospital service can be served without an undue burden on those counties with medical services and facilities.

(3) The general background of financial problems now facing voluntary public and private hospitals, such as increased costs of providing service, methods used to finance operating deficits; the extent of extra charges to paying patients to cover the cost of indigent care; discounts to third party payees of service, nurse training and the like.

(4) The legal responsibility, if any, which the state, the counties, cities, or other public authorities might have in providing care for the indigent sick.

(5) The effectiveness of indigent care programs in other Southern states, cost of such programs and methods of financing and operation.

(6) The suggestion of a plan or plans that Georgia should follow in providing hospitalization and treatment for the indigent sick, including the methods and procedures by which such hospitalization can be provided.

Financial Problems of Hospitals

Provision of care for citizens unable to pay is one of the most common yet perhaps the most pressing hospital problem today. There is no such thing as free hospital care. Somebody must pay for the maintenance of the many expensive services provided by hospitals. Hospitals have three possible sources of income: donations, pay-patients, and tax funds. The situation in this country today is that the sick patient who pays is having to shoulder most of the burden of keeping hospitals open. The patient is being forced to pay, not only for his own care, but for the cost of those who cannot pay, as well as uncollected accounts, vacant beds, maintenance, educational and other similar activities of the hospital.

This situation exists because philanthropic donations for the operation of hospitals are largely a thing of the past. Many local governmental units are reluctant to tax healthy citizens in order to purchase hospital care for the sick who cannot pay. This system of financing hospital care has resulted in the over-charging of paying patients, low salaries for hospital personnel, deteriorated hospital plants due to improper maintenance, or in minimum patient care service. Financially speaking, many hospitals are just as sick as the patients within their walls due to

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rendering a large volume of community service.

The financial problems of hospitals are not going to be solved until the following things are accomplished:

- (1) The individual citizen gives medical care a higher priority within the limited family budget of expenditures.
- (2) More prepaid hospital insurance, such as Blue Cross (non-profit) is available to those in unorganized groups and in the lower income brackets.
- (3) More citizens are willing to be taxed at the state and local level in order to purchase medical and hospital care for those unable to pay for this care.
- (4) More hospitals recognize the need for lower costs and make every use of the most modern administrative techniques to increase efficiency and reduce costs without decreasing the quantity or quality of service.

The Situation in Georgia

Means for providing hospital and medical services for the indigent citizens of Georgia are not available in many counties. At the present time there is no uniform method of providing for medical and hospital care for this group of citizens. One might say there are 159 methods in 159 counties in Georgia, and that the majority are methods of evading the issue rather than providing adequate care. There are eight counties in Georgia (Baker, Banks, Chattahoochee, Crawford, Dawson, Echols, Lee, Webster) according to the Medical Directory of Georgia that are without a physician in private practice. In addition to those counties there are 56 counties in the state without hospitals; the people in these counties must depend on physicians and hospitals in adjoining counties to provide medical care services. In these counties, nothing or an insignificant amount is spent for hospitalization or for medical care of the indigent. The indigent in these counties do not receive hospital care, or they are dumped on surrounding counties, or care is provided by the hospitals at the expense of increased cost of hospitalization to the paying patients. Many of the counties

with hospitals do not make provision for their own indigent. According to a survey made by the Division of Hospital Services of the Georgia Department of Public Health in March 1955, only 40 hospitals out of 92 hospitals in the state reported receiving any local payments for indigent and medically indigent care. (Tables 1 and 2)

The method used by counties to determine eligibility for public assistance for hospital care was reported as follows:

	Number	Percentage
(1) Determination made by county welfare	27	67.5%
(2) Determination made by hospital only	4	10.0%
(3) Other methods: (county ordinary, county commissioners)	9	22.5%

Approximately 30 counties in the State levy a specific millage tax for the support of the local hospital or for payment for indigent care. These counties levy a tax ranging from one mill to seven mills. Two counties have a beer tax which is used for the support of hospitals. Ten additional counties without a millage tax for hospital support make a contribution (either county or city) from general operating funds. In the 40 counties with some type of compensation for the hospitalization of the indigent, payments are inadequate to meet the actual cost of such service. Also such funds do not follow indigent patients that may be hospitalized outside the county. The 119 counties that do not make provisions for indigent hospitalization are primarily those counties that are relatively remote from large cities, small in population, or low in taxable wealth. County lines act as barrier in planning for adequate medical care in Georgia. There is reason to believe, based on county infant and maternal mortality rates, that a substantial number of indigents in Georgia do not seek or get medical care when needed.

Hospital care for the indigent sick is primarily the responsibility of the community in which such patients live. This responsibility should be dis-

Hospitals in Georgia Receiving Payments for Indigent Care

By Bed Size	Total Reporting	Receiving Payment	
Under 10	23	0	0%
10-24	15	6	15.0%
25-49	29	19	47.5%
50-99	9	6	15.0%
Over 100	16	9	22.5%
Totals	92	40	100.0%

Table 1

By Ownership	Total Reporting	Receiving Payment	
Private	40	2	5.0%
Non-Profit Association	10	5	12.5%
Hospital Authorities	42	33	82.5%
Totals	92	40	100.0%

Table 2

charged by the smallest political unit that can effectively do so, but in Georgia many counties are so small in population and so low in per capita wealth that they cannot effectively discharge this responsibility without help.

The burden of hospital care to the indigent, if not met by tax funds or private charity, must be financed by those patients who pay their own way. In effect, the cost of indigent hospitalization is borne largely at present by a tax on hospital charges—a tax on sickness. This problem has been studied in other Southern states, and these reports reveal that a state

fund with county participation is the most successful means of providing hospital care for the indigent and for improving the hospital care for all citizens of the state. The State of Georgia should assume part of the responsibility for indigent hospitalization in order to encourage local participation and to insure that none of its citizens are deprived of necessary medical care because of inability to pay. A study to seek a solution and to recommend a program to meet this problem should be initiated immediately in Georgia

33 Gilmer Street, S.E.

Trapping Project Now Underway Planned To End Rabies In Georgia

THE TIME MAY SOON COME when Georgia will be free of the anxiety and expense caused by rabies among dogs, cattle, and wild animals. Georgia is one of three states taking part in a state-federal vaccination and trapping project to completely eradicate rabies within the area of Georgia, Alabama, and Florida.

The project is sponsored jointly by the three states and the Communicable Disease Center of the U. S. Public Health Service under a special \$50,000 anti-rabies program. The Center, which has headquarters in Atlanta, has assigned a veterinarian to each of the three states to assist with the project.

Announcement of Georgia's part in the project comes from T. F. Sellers, director of the Georgia Department of Public Health, and Dr. L. E. Starr, veterinarian of the Health Department. Other agencies taking part in the project are the State Game and Fish Commission and Federal Wildlife Service. The additional veterinarian assigned to the Georgia Health Department is Dr. Robert Watson.

Biologic Imbalance Not Intended

"In the proposed tri-state program," Dr. Sellers said, "we have no intention of disturbing the natural biologic balance relating to wild animal life species. Our object is to get rid of rabies, which is a menace not only to public health but also to wild and domestic animal life."

Georgia, Florida, and Alabama were chosen for the project because they are better isolated geographically than any other area in the nation, Dr. Sellers said. These states are for the most part surrounded by the natural barriers of the Atlantic Ocean, the Gulf of Mexico, the Savannah River, and the mountain ranges of the north.

Rabies is at the lowest ebb in Georgia in several years, said Dr. Starr. There have been no epidemics this year, but there have been small outbreaks in about 30 counties, mostly in central Georgia.

Efforts Where Rabies Exists

"We plan to concentrate our efforts entirely in areas where rabies in animals is known to exist, regardless of species of animals involved," Dr. Starr said. "We plan to stimulate the vaccination of dogs and livestock, as well as to encourage dog owners to keep their dogs under control so they will not be exposed to rabies. As in the past, dog vaccination and control will be under the sponsorship and direction of the individual county boards of health, with state assistance when desirable."

"We also hope," he said, "to thin the population of wild life in the immediate areas where rabies infection is known to exist—this may include several counties or parts of counties. This is best accomplished by trapping in the fall, winter and spring."

Trapping to Be Rapid

The trapping in each area will be completed as rapidly as possible, Dr. Starr said, and sportsmen who use dogs in their hunting can ask local health departments when and where traps are to be set out so the dogs will not get caught in them.

Dr. Starr said he wanted to assure sportsmen that the trapping program will take out not more than 25 per cent of the animals, which will decrease the wild life population so that it will not support a rabies epidemic.

It may be advisable to vaccinate cattle in areas where rabies is prevalent. "We suggest that cattle owners consult their local veterinarian," said Dr. Starr.



Physicians and Lawmakers

LAST MONTH THE JOURNAL published the names of Georgia's 10 Congressmen and two Senators, together with instructions as to how to contact these national representatives. In this issue, on the back of the Secretary's Page, is found a roster of members of the Georgia General Assembly. Why is this information being published?

On a number of occasions, physicians have shown an extraordinary lack of interest in matters pertaining to the U. S. Congress and the Georgia General Assembly, and yet the actions of these lawmaking bodies affect and will continue to affect the practice of medicine in Georgia as we know it today.

In the editorial below is a brief discussion of a bill which was introduced in the House of Representatives and is known as H.R. 7225 which probably constitutes the most serious threat to the private practice of medicine in recent years. In the Secretary's Letter (yellow page) of this issue, is an outline of medical legislation that will probably be considered in January by the Georgia General Assembly.

To meet certain responsibilities to our patients and to the medical profession, we should familiarize ourselves with national and state legislation when it concerns health and medical matters. It is our duty to contact our representatives and make our views on this type of legislation known to them. In many instances, individual legislators have asked for our views.

In the past, particularly on the state level, we have taken too little interest in legislative affairs, and as a result laws have been passed which have not contributed to the high quality of medical care which the people of Georgia deserve. These laws might never have been enacted if the public and the legislators had been fully informed, by those most qualified to inform them, the medical profession.

We urge you to seek out your state and national representatives. Get to know them and let them know your views on legislation affecting health and medical matters.

Galloping Socialism

NO DOUBT YOU'VE HEARD of "creeping socialism," but you may not be familiar with the new form of socialism that has been "galloping" through congress.

We are speaking of H.R. 7225 which, when passed

by the Senate, will amend Title II of the Social Security Act to provide cash disability benefits for totally and permanently disabled persons at age 50; reduce to age 62 the age on the basis of which benefits are payable to working women; and extend coverage in general.

This bill was literally rammed through the House of Representatives last July without public hearings and with very limited debate. It is now in the Senate Finance Committee, of which Senator Walter F. George of Georgia is a member, and former chairman. H.R. 7225 will be acted on by the Senate during the 1956 session.

Why is H.R. 7225 particularly dangerous to the practice of medicine? What is it in the bill that has an adverse impact on the physician?

First of all, the law does not clearly define total and permanent disability, and provisions are made not only for physical disability but for mental disability. When an individual feels he is eligible to receive cash benefits and when he is one of 200 thousand constituents of our congressmen who want to be included under the program, there is going to be considerable political pressure on the administrators of the system, and on the physician who makes the determination, to certify that this individual is disabled. In periods of low employment one can see how this situation would be magnified many times, and the pressures on the physician would be even greater.

Secondly, H.R. 7225 would be detrimental to our rehabilitation program in that cash disability benefits would remove the incentive to rehabilitate. It is through the rehabilitation aspects of this program that the Department of Health, Education and Welfare will control the medical care for this large group of disabled persons.

Thirdly, the proposed law would open the door to greater and greater expansion of the entire social security program. Why stop at age 50 for cash benefits to disabled persons? What about those who are 49, 40, 35, etc.? What about the dependents of the totally disabled group? Shouldn't they receive cash benefits? What about the partially disabled? It is inevitable that these further expansions will be sought at future sessions of Congress.

Commenting on H.R. 7225, in the *JAMA*, November 5, page 1017, the AMA has this to say:

"Social security has developed over the past 20 years to the point where it is no longer an experiment; it now is a major cog in our national econ-

omy, directly affecting the income, purchasing power, and life planning of most people. By the same token, it also has reached a magnitude where any further changes may have a profound influence on the nation's economic, social, and political future. The experience of the past two decades has demonstrated the danger arising from the nation's failure to decide just what social security is supposed to accomplish and just where it is supposed to stop. Bills liberalizing the program never contain any specific, well-defined limitations. Year after year the members of Congress introduce a growing number and variety of proposals—calling for still more changes, still greater expansion, still newer types of coverage. Prior to summer adjournment this session, for example, 247 such bills were dropped in the congressional hoppers.

"This trend is moving closer and closer toward the fields of disability, rehabilitation, and medical care. The questions that it raises, however, concern not just the medical profession but all of the American people. Those vital questions involve not only the philosophy of the social security program but also its cost and tax burden—particularly as they affect the future generations who eventually will have to pay the piper. By lack of foresight and of sober study, by reckless disregard for the economic realities of increasing liabilities and costs, we might ultimately wreck the social security system itself."

It behooves every physician in Georgia to study H.R. 7225. For sound laws, study and investigation are necessary. *Urge your Senators and Representatives to undertake a complete and thorough study of the entire social security act before legislating any further amendments.*

Statistics, Sophistication, Sophistry and Sacred Cows

WE ARE ALL SNOBS,[†] of course. The ego, sometimes referred to as a fragile gossamer thing, actually has an omnivorous appetite. It subsists on a diet of favorable comparisons with other egos over which it possesses a real or imagined superiority. Medical research has always provided a bounteous banquet-

table for starved egos, but in recent years has begun to nourish in greater numbers persons whom I shall call Statistical Snobs.

There are two main varieties of Statistical Snobs. The first of these is the Professional Illiterate, or Statistical Hayseed. He professes a great disdain for all statistics, and boasts of his ignorance of statistical principles and technics. In ghoulish glee, he points to such books as *How to Lie with Statistics*,¹ and reminds you that "you can prove anything with statistics," or (on alternate days) that "nothing has ever been proven with statistics." He sneers at the "Ivory Tower Boys" who "just don't realize what the practice of medicine and the problems of clinical research amount to." He is shocked at the thought of controlled experiments, where some patients receive placebos and are thus "denied the benefits of treatment." (With typical largesse, this objection is leveled at all treatments, be they established ones of proven efficacy, or untested drugs or procedures which not infrequently turn out to be more deleterious than no treatment at all.) He is fond of writing papers (summarizing uncontrolled observations) which he admits are inconclusive, but usually end with: "The results are promising and warrant further investigation." His prevailing philosophy ranges from absolute nihilism to rapid and complete ingestion (sans mastication) of new claims, since he lacks any standard of reference for evaluation other than an ill-defined, ectoplasmic link with the Unknown referred to as My Clinical Judgment, or My Past Experience. These individuals, while all too real, are an old phenomenon on the American scene, and actually less annoying in some respects than the second major type of Statistical Snob—the Chi Square Cavalier.

The Chi Square Cavalier, or T-test Terror, is a crusader for statistics in the scientific world. To him a paper without at least one probability value is a shuddery concept. As rigidly doctrinaire as the Statistical Hayseed, he would apply his technic to all data, even when it is not desirable or possible to do so. Since many of these Cavaliers know only enough statistics to impress those who know none at all, some rather amusing things occur at times. Data which have been collected in such a way that comparison of treatments is meaningless are subjected to exhaustive scrutiny. Matched data are treated as independent data, or vice versa. Large sample technics are applied to samples of microscopic size. A moderate amount of knowledge in this field is not, however, an impregnable bulwark against error. As a matter of fact, a special type of mistake is probably most commonly committed by a more advanced group of Chi Square Cavaliers.

Reprinted from *Clinical Research Proceedings* 4:185-187 (Nov.) 1955, with the permission of the author and the publisher, Grune and Stratton.

[†]With apologies to Russell Lynes.

The error to which I refer is the Microstatistical Mirage. Papers may be found in which "highly significant differences" are described, but which on careful reading seem to be concerned with extremely small differences which have been shown to be significant only by the use of very large samples. Several examples may help to illustrate the field of Microstatistics‡

One paper reported the results of a study of antitussive drugs. The numeric scale for the severity of cough was from 0 to 4, as follows: 0, indicating no cough; 1, occasional, barely troublesome cough; 2, moderately troublesome cough; 3, markedly troublesome cough; and 4, incessant and distressing cough. Eleven thousand observations were made, with "highly significant" differences being established between treatments. When one looks at the figures, however, it is interesting to see that the most "potent" drug studied (codeine) caused a drop in mean severity of cough (from the 1st to the 5th days of observation) from 1.33 to 1.09, whereas the placebo caused a change from 1.58 to 1.53. Obviously the average severity of cough studied was mild, and the mean decrement after treatment small indeed.

Another paper was concerned with the calming effect of Rauwolfia on a group of agitated psychotics. Again we find large numbers of observations made (over 400 patients were studied), with the following "highly significant" results:

	Premedication	Placebo	Raudixin	Serpasil
% Noisy	19	19	15	14

The difference between the Rauwolfia and non-Rauwolfia conditions . . . is significant at the 1 per cent level of confidence.

Without denying the validity of small differences, one wonders whether the cause of progress is not better served in such instances by accenting the essential insignificance (from a practical standpoint) of such results.

The antipode of the Microstatistical Approach is presented by the Tunnel Vision (or Close-But-No-Cigar) School, members of which steadfastly refuse to call any attention to differences which do not reach some mystic probability level, no matter how close they may come to achieving this point. Even when a small series has been studied, and there is good reason to suppose that a few more cases would have allowed penetration through the Magic Wall of p. 0.05 Fire, we find the observed differences being curtly dismissed as "not significantly different." As Kennaway has recently pointed out,² there are very interesting examples of minute (but important) small differences which are almost impossible to

demonstrate "statistically" under ordinary circumstances. He cites Haldane to the effect that the increase in length of ceratopsian dinosaurs from 1.7 to 6.5 meters in 22 million years took place (at the beginning of the period) at the rate of 1 mm. per 10,000 years. One can picture an early caveman snob telling another caveman that "All this rot about the dinosaurs getting bigger is just erroneous clinical impression, old man."

Another kind of Statistical Snob is the Placebo Pusher (or Double Blind Dodo). Having learned the magic words "placebo" and "double blind," this species insists that any report in the literature not containing these controls constitutes a complete waste of everyone's time.

If some happy clinician reports twelve cases of pathologically proven metastatic carcinoma cured within two weeks by some new drug, with maintained cure for ten years, the Dodo screams for "placebo controls." If someone reports a series of 50 cases of staphylococcal meningitis, randomly distributed to two treatment groups, with 90% survival in one and 0% in the other, the Dodo sneers, "Were the people involved in making the value judgments as to life or death kept unawares of the nature of the two medications, and did the patients know which drug they were getting?"

Like all militantly dogmatic groups, the Placebo Pushers are blissfully unaware of certain incongruities in their attitudes. For example, if one is studying the effects of nicotinic acid, injected intravenously, on headache, it is difficult to keep the injector in the dark as to which medications are nicotinic acid and which are saline, unless he is physiologically blind. (It would also help if he were deaf, so as not to hear the patient's comments.) One can get around this problem by using one person to inject and another person to evaluate the results, but how does one fool the patient in this case? The patient who has just got a big dose of nicotinic acid (or apomorphine, or veratrum) will usually have little difficulty in distinguishing such injections from saline.

The Placebo Pusher also has his counterpart among the nonbelievers. One recent study concerned itself with the analgesic effects of aspirin in a group of patients with chronic complaints referable to the musculoskeletal system. Having failed to show a difference between placebo and aspirin, the authors came to the astonishing conclusion that the double blind technic was not suited to the demonstration that aspirin was an analgesic drug in patients of this sort! This statement would seem equivalent to borrowing the favorite rifle of a crack marksman, missing the target, and then blaming the poor performance on the gun.

‡I hope that those statisticians who refer to the statistics of small samples as microstatistics will excuse the above usage.

A final bit of Statistical Snobbery will be included because of its direct significance for the writer of this paper. Recently, I discussed a large series of patients who were subjected to portocaval shunts. During the early years of experience with this technic (the same surgeon did all the cases) one type of anesthesia was employed. During the later years, a second type of anesthesia became the preferred one. Since the passage of time was also associated with changes in patient selection, surgical technic, use of fresh blood, etc., I suggested that it would actually be more sophisticated for the authors to describe the results as "our experience during the first two years" and "our experience during the last two years," rather than analyze the data statistically for differences in morbidity and mortality, with an eye toward comparing the two anesthetic agents in this procedure. One critic commented that there was no point in publishing data such as these. I could hardly disagree more. Any doctor with a patient or relative with cirrhosis of the liver would be most interested to know that, as of 1955, there is a surgeon around capable of doing portocaval shunts with a

very low mortality, regardless of whether he is able to put his finger on the reasons for the low mortality, and regardless of whether he can learn from the data in the paper if ether and cyclopropane differ in their safety in this situation.

As is all too obvious, some of the descriptions above have been purposely exaggerated. These parodies are intended to emphasize certain errors which are met with all too frequently at meetings and in articles. As with most things, almost every point which has been attacked has much merit per se. In the blind or rigid application of even praiseworthy principles, however, ridiculous excesses creep in. Having been personally guilty, at one time or another, of most of the foibles satirized here, I feel considerable freedom in directing these remarks to any fellow sinners in the audience. The comments are presented not so much in the nature of stone-casting as to indicate the extreme vulnerability of the Statistical Snob to criticism by the Editorializing (or Converted Sinner) Snob.

Louis Lasagna, M.D.

Johns Hopkins Hospital

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2. Kennaway, E.: The statistical significance of biological data. *Brit. Med. J.* 2:663, 1954.

American Association for the Advancement of Science

APPROXIMATELY 1,000 PAPERS covering all branches of science will be presented at the 122nd national convention of the American Association for the Advancement of Science in Atlanta, December 26-31, 1955, at the City Auditorium. The subject matter of these talks will range from astronomy, "The International Geophysical Year Earth Satellite Program," to zoology, "Freezing and Freeze-drying of Bull Spermatozoa."

This meeting of the AAAS, the largest and most influential group of related scientific organizations, will include sessions of 17 sections of the Association; the national meetings of the clinical chemists, phytopathologists, parasitologists, science teachers, and zoologists; the regional meetings of geophysicists, biologists, physiologists, psychiatrists and other medical groups; and the membership of the large Association of Southern Agricultural Workers.

This is the first meeting held in the Southeast by the AAAS since the Atlanta convention of 1913 and is expected to attract more than 3,000 scientists from all sections of the United States and other parts of the world.

The AAAS is a nonprofit organization which exists to further the work of scientists, to facilitate cooperation among scientists, to make science more

effective in promoting human welfare, and to increase public understanding of science. Associated or affiliated with the AAAS are 256 societies, such as the American Chemical Society, American Society of Zoologists, American Medical Association, American Psychological Association, American Physical Society and others. The aggregate memberships exceed two million.

Three Atlantans hold high offices in the AAAS. They are Dr. Robert S. Ingols, Research Professor, Georgia Tech Engineering Experiment Station, AAAS Vice-President and Chairman of the Chemistry Section; Dr. J. Fielding Reed, Southern Manager, American Potash Institute, AAAS Vice-President and Chairman of the Agriculture Section; and Dr. M. J. Goglia, Professor of Mechanical Engineering, Georgia Tech, Program Chairman of the Engineering Section.

Thousands of common home, industrial, and agricultural chemicals may be potential killers. To insure proper handling of these products, the AMA's Committee on Toxicology and Committee on Pesticides will sponsor a symposium on health hazards of chemicals in Atlanta on December 29 during the annual meeting of the AAAS.

Postpartum Myocardosis

SAMUEL O. POOLE, M.D., Gainesville, Ga.

A GREAT DEAL has been written about the effects of pregnancy on the heart, and we have extensive knowledge of heart failure during pregnancy. Although rare, heart failure does also occur in puerperium, and at present our knowledge on this subject is meager. Decompensation during the puerperium in many instances is due to the usual etiologic types of heart disease. More rarely, however, postpartum heart failure occurs in the absence of the usual causes of heart disease and in patients whose hearts were considered to be normal during pregnancy. Heart failure occurring in such instances has gone under the name of "Post-partal Heart Disease," "Postpartum Myocarditis," "Postpartum Myocardosis," "Toxic Post-partal Heart Disease," and "Idiopathic Myocardial Degeneration Associated with Pregnancy and Especially the Puerperium." There still exists in the minds of many people considerable doubt as to whether or not postpartum myocardosis is a true clinical entity. Regardless of this, heart failure occurring in the puerperium always presents a problem, and this syndrome—if it is a syndrome—should be born in mind.

The clinical features of the illness are fairly well defined. The first symptoms usually appear between the second and sixth week after parturition but may have been transitorily present in the last few weeks prior to delivery. Dyspnea, cough, orthopnea, and edema are noted, and at times the edema may be extensive with pleural effusions and ascites. The pulse rate is rapid, and a diastolic gallop rhythm is nearly always present. The heart is enlarged, massively at times, but x-ray and fluoroscopic studies have revealed no specific chamber enlargement. The diastolic pressure is nearly always elevated and the pulse pressure may be small. The electrocardiogram is abnormal, but the changes are not specific. Pulmonary and peripheral emboli are quite common and are a frequent cause of death.

Characteristically this type of postpartal heart failure has been refractory to treatment and slow to respond. The over-all prognosis is said to be good, but obviously in dealing with such an ill-defined entity this is difficult to evaluate. The follow-up studies on patients reported in the literature has not been good. Many patients recover without residual damage, but persistent cardiomegaly has been noted in

some, and recurrences after subsequent pregnancies have been reported.

The pathological changes may be focal or diffuse throughout both ventricles. The most outstanding feature in the acute phase is a degeneration of the myocardial fiber with only minimal inflammatory cell infiltration. In older lesions fibrosis does occur. Mural thrombus formation is common and at times may be extensive. This is felt to be due to extensive subendocardial muscle degeneration. The coronary arteries are normal. The changes are different from those seen in rheumatic fever and Feidler's Myocarditis. The muscle changes are similar to but not identical with those seen in beri-beri.

The etiology of postpartum myocardosis is still unknown, but its relationship to pregnancy and the puerperium brings up many interesting possibilities. Hypertension may be a contributing factor and toxemia of pregnancy may play a part, but the pathological features seen in these patients are not those seen in patients dying from essential or malignant hypertension. Endocrine factors may be significant, and thyrotoxic heart disease has been considered, but in the reported cases this does not seem to be of any importance.

The clinical features of beri-beri heart disease and postpartum myocardosis are similar, but signs of vitamin deficiency and peripheral neuritis have not occurred in the latter. The lack of response to specific thiamine therapy and its occurrence in the postpartum period when vitamin requirements are lessened would seem to point against this being a form of beri-beri. As mentioned above, the pathological changes are similar but not identical.

Another contributing cause that has not been given too much attention in the literature is the occurrence of pulmonary emboli. Some feel that this type of postpartum heart failure is heart failure precipitated by recurrent pulmonary emboli. On careful study of the literature it is obvious that this may be the sole cause of some of the cases reported as postpartum myocardosis, but it is not the explanation of all cases.

Whether or not postpartum myocardosis or postpartal heart disease exists as a clinical entity is still undecided. It is possible that diffuse myocardial disease occurring in the puerperium may be due to a number of etiologic agents. Careful observation with good follow-up study should soon solve this problem.

Prepared at the request of the Committee on Professional Education of the Ga. Heart Assn.

abstracts by georgia authors



Shivers, Olin, 33 Ponce de Leon Ave., N.E., Atlanta, Ga. "Behavior Problems and Pediatric Allergy," *SOU. MED. J.* 48:980-984 (Sept.) 1955.

The emotional problems and outlook of many allergic children have been shown to have an effect upon their disease symptoms.

The similarity in personality types in the family group of an allergic child has been noted with interest. Though not always present by any means, some facets of the following are most often present: the mothers are seldom the casual, easy-going mothers we often see with other patients. They are serious, and know that bringing up a child is serious business. They are anxious to let us know the depth of concern they have for their child. They are overprotective and exhibit concern over all the details of the child. They want us to give straightforward answers to a lot of questions which will give them rules to abide by in handling the patient. They are highly critical of their offspring and express eagerness to do anything if it will help the child grow up to be a credit to themselves and resemble their heavily preconceived notion of what is a healthy, normal, happy adult.

The allergic children tend to be on the shy side. They cling to their mothers, lack self-confidence, and often mix rather poorly with other children. There is a closeness between them and their mothers.

The fathers are often quiet types, usually not actively interested in their child's activities.

It is helpful to keep in mind the concept of the "total allergic load." A heavy blast of psychological factors may lower a patient's tolerance to the point that minimal weighting of his load of physical allergens will tip the scales toward a full display of his symptoms. Allergic factors which would ordinarily result in only subclinical allergy can produce marked symptoms in the presence of an unresolved emotional problem.

If we are to treat completely an allergic child, we must be on the alert for such

emotional problems as we proceed with the more routine investigation and treatment. The physician should have at hand the time, the attitude, and some suitable techniques to deal with them when they come to light.

Bauer, Heinz, John F. Flanagan and Walter H. Sheldon, Emory University School of Medicine, Emory University, Ga. "Experimental Cerebral Mucormycosis in Rabbits with Alloxan Diabetes," *YALE J. BIOL. & MED.* 28:29-36 (Sept.) 1955.

We have been able to produce typical cerebral mucormycosis by intranasal instillation in alloxan diabetic rabbits, and lesions failed to appear in normal control animals. The disease can be produced by several fungi of the order Mucorales and resemble closely those found in human cases. This also confirmed the theory that the paranasal sinuses can be the portal of entry. Invasion of blood vessels by the fungus accounts for much of the spread of the infection and for some but not all morphologic aspects of the lesions. The inflammatory reaction was diminished in intensity in the diabetic rabbits with most of the polymorphonuclear leukocytes showing degeneration. Metabolic alterations such as are associated with diabetes mellitus appear to be an essential factor in the pathogenesis of this disorder.

Leigh, Ted F., Robert P. Kelly, and H. Stephen Weens, Emory University Hospital, Emory University, Ga. "Spinal Osteomyelitis Associated with Urinary Tract Infections," *RADIOLOGY* 65:334-342 (Sept.) 1955.

Spinal osteomyelitis sometimes develops following urinary tract infections. It is felt that the route of the infection is from the urinary tract to the spine by way of the pelvic veins and the vertebral venous plexus. It has been proven anatomically by Batson that there are numerous intercommunications between the pelvic and the vertebral veins and that in the presence of obstructions in the inferior vena cava, the blood flow is routed through these systems.

Radiologically, the films show varying degrees of destruction in an intervertebral disc and in the bodies of the adjacent vertebrae. The radiological findings often lag behind the clinical findings by a matter of weeks or even months, and if this condition is suspected repeated examinations should be made at intervals until the condition becomes apparent.

At times the organism causing the infection can be recovered from the spine by needle biopsy.

Nine cases with selected roentgenograms are presented.

Manchester, P. Thomas, Jr., 478 Peachtree St., N.E., Atlanta, Ga. "Advising Patients with Hereditary Eye Disease," *AM. J. OPHTH.* 40:412-417 (Sept.) 1955.

Essentially all the hereditary eye diseases may be classified as either dominant, recessive, or sex-linked recessive, although some may appear in any of these forms. Charts are presented showing the more common hereditary eye diseases and their usual modes of inheritance. Calculations are given as guides for the physician in advising the patient, his parents, and close relatives regarding the question of their having more children.

Wolff, Bernard P., 384 Peachtree St., N.E., Atlanta, Ga. "Respiratory Alkalosis with Especial Reference to Chest Pain," *DIS. OF CHEST* 28:337-342 (Sept.) 1955.

Though the symptoms of respiratory alkalosis (hyperventilation syndrome) are bizarre and varied, the condition is being recognized more often. The chronic case is seen more frequently than the acute. The chest pain accompanying respiratory alkalosis is thought to arise chiefly from the diaphragm. The author also believes some cases of over-breathing are produced by stretching and loss of tone of the diaphragm as well as by the resultant compression of the lung bases. Strenuous exercises coupled with simple explanation of the nature of the syndrome seemed to produce the best treatment results.

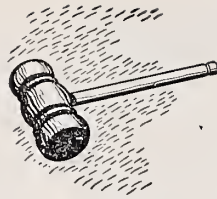
Georgia Facilities for Chronically Ill

GEORGIA RANKS RELATIVELY LOW in providing facilities for the chronically ill and for nursing home patients. Only six per cent of the need for chronic disease patients has been met. Ten per cent of the need for nursing homes is available. Only eleven per cent of the need for diagnostic and treatment centers has been met. No comprehensive multiple-disability rehabilitation facilities are available in Georgia.

In 1953 the Division of Hospital Services made a study of patients in the nursing homes in Georgia. It was found that the typical patient in such facilities

was a white widowed female in her middle seventies. The typical home was privately owned with about 20 beds, located in a metropolitan area. The average patient had been in the house for almost 18 months and her care, which cost about \$84.00 per month, was being paid for by the patient or by a relative.

Under the amendment to the hospital construction law, the Health Department will promote comprehensive diagnostic and treatment centers for ambulatory patients in conjunction with hospitals already having such services for bed-care patients.



president's page

THE GOVERNOR'S BREAKFAST CONFERENCE on Mental Health was a most thought provoking meeting. The Governor's interest in the recovery of those already suffering from severe mental illnesses and now confined under commitment in our State Hospital was most refreshing and encouraging.

The question of screening centers was uppermost in the minds of the group, and there seemed to be some disappointment when the three psychiatrists present were almost simultaneous in announcing that screening centers that now exist in several states had not decreased the rate of growth of state mental hospitals.

The rate of growth per 100,000 population for the entire United States shows an increase of three patients per year. This, however, reflected to yearly admissions amounts to approximately 15 per cent. In Georgia this amounts to 450 added beds per year.

Two states, Michigan and Kansas, have at least reversed this trend and show an actual decrease in the number of patients in residence in their state mental hospitals. W. C. Menninger speaking before the joint session of the Ohio legislature explains this improvement in Kansas in an address entitled "Brains Before Bricks."

Several states show no increases in mental patients in their state hospitals. Two entirely projected explanations are decreasing population or utter exhaustion of capacity for added beds.

We often hear that there is no shortage of physicians but rather a relative shortage due to poor or improper distribution. The employment, however, of just one physician for each 50 beds already occupied 100 per cent in state hospitals alone would require 12,000 more physicians. If the rate for patients in residence in New York State Hospitals held for the rest of the States, there would be a need for 20,000 more physicians. If the rate were that of the District of Columbia, 30,000 more physicians would be needed.

Without disturbing the admissions and early treatment beds at the Milledgeville State Hospital, the State of Georgia can use 150 beds in the Eugene Talmadge Memorial Hospital and an equal number of the new Grady Hospital in Atlanta for early or even precommitment treatments. This should surely create a healthy competition between these three centers with great benefit to the patients, the training of medical students, and perhaps a few more psychiatrists.

H. D. Allen, Jr.

Executive Committee of Council

Atlanta, November 3, 1955

The Executive Committee of Council meeting in regular monthly session, was called to order by Chairman H. Dawson Allen at 4:30 p.m., November 3, 1955 in the Academy of Medicine. Present were: H. Dawson Allen, Milledgeville, President; Hal M. Davison, Atlanta, President-elect; David Henry Poer, Atlanta, Secretary; J. W. Chambers, LaGrange, Chairman of Council, and Bruce Schaefer, Toccoa.

Meeting jointly with the Executive Committee were the following members of the Legislation Committee: Grady Coker, Canton, Chairman; Albert Deal, Statesboro, and J. D. McElroy, Atlanta. Also present were Thomas F. Sellers, Director of the Georgia Department of Public Health, the Messrs. Milton D. Krueger and John F. Kiser.

The minutes of the last meeting were read and approved.

Chairman Allen called on Legislation Committee Chairman Grady Coker for a discussion of the Medical Association of Georgia legislative program:

- (1) Introduction and support of the Medical Care Commission.
- (2) The repeal of the present Naturopathy Law.
- (3) Introduction and support of an amendment to the Talmadge Memorial Hospital Enabling Act.

In support of this Association legislative program, it was moved (Chambers-Schaefer) that Mr. John Kiser be authorized and instructed to make every effort to publicize and make known the Association's viewpoint on these three matters.

Certain irregular appointments made by the Governor to the State Board of Health were discussed. The Executive Committee deferred action until such action was requested by any of the district medical societies involved.

A motion (Schaefer-Davison) was made approving a statement drafted by members of the Executive Committee which reads as follows:

"The Executive Committee of Council of the Medical Association of Georgia, Thursday, November 3, 1955, hereby pledges its continued wholehearted support toward the development of the Medical College of Georgia and its 800 bed teaching facility, the Eugene Talmadge Memorial Hospital. Throughout the years, the Association has always cooperated in every way possible with the Medical College of Georgia and declares again that it intends to continue this cooperation and support and will assist the advancement of this fine medical institution. A large majority of the members of the Association are graduates of the Medical College of Georgia, and all members are willing to devote both time and funds to improve medical education in Georgia, to the end that the people of this state, both rich and poor, may receive the high quality of medical care which they deserve.

"The Association, representing the medical profession in Georgia, also reaffirms its position in regard to the Board of Regents plan to admit private patients to the State-operated Eugene Talmadge Memorial Hospital. The Association, as it has in the

past on numerous occasions, opposed the admission of professional pay-patients to this tax supported institution on the grounds that this plan violates the medical code of ethics. A long and splendid record of the Medical College of Georgia in educating Georgia physicians without inclusion of professional pay-patients is proof that no change in this policy is needed. The Association firmly believes that this past experience confirms its position with regard to the basic principles of medical education which have been so well tested in over one hundred years in this State.

"The Association is opposed to any hospital in Georgia that charges fees for general professional services of doctors. This position which has been taken by the Association after considerable study and investigation, will in no way alter the wholehearted support to the Medical College of Georgia, which has been offered on many occasions while at the same time deploring their departure from their former (and successful) methods of teaching.

DAVID HENRY POER, M.D.

Secretary-Treasurer

Medical Association of Georgia."

This statement was approved by the members of the Executive Committee of Council as representing the Association's position.

By general agreement, the executive secretary was authorized to make an appointment for certain members of the Executive Committee of Council to breakfast with the Governor of Georgia sometime after the 20th of November.

The Executive Committee of Council, on motion duly made and seconded, approved the following changes in names of component county medical societies: Clarke-Madison-Oconee Medical Society to Crawford W. Long Medical Society; Brooks County Medical Society and Thomas County Medical Society to Thomas-Brooks Medical Society; Crisp and Dooley County Medical Societies to Flint Medical Society; Hancock and Morgan County Medical Societies to Oconee Valley Medical Society; Toombs and Montgomery County Medical Societies to Southeast Georgia Medical Society; and Forsyth and Gwinnett County Medical Societies to Chattahoochee Medical Society. Also approved was the constitution of the Walker-Catoosa-Dade Medical Society. The executive secretary was instructed to forward their charter at once.

Mr. Krueger, the Executive Secretary, submitted his monthly report for information and referral only. Mr. Krueger discussed (a) employee salaries; (b) book-keeping equipment, and (c) Council room chairs. These items were all referred to the Audit and Appropriations Committee for their study.

Lester Rumble, Jr., Chairman of the Crawford W. Long Memorial Committee, submitted a report as requested by Council concerning the proposed placement of a bust of Georgia's Crawford W. Long in the State Capitol Building, Atlanta, at the suggestion of the UDC. Dr. Rumble's report urged that the above proposal not be turned down, but that it be held in abeyance until the Association fulfills its commitments in connection with the museum, in honor of Dr. Long, under construction at the present time in Jefferson, Georgia. Dr. Rumble's report was accepted as submitted.

David Henry Poer brought to the attention of the

Executive Committee, the inaccuracy in the numbering of the Medical Association of Georgia's annual sessions. Dr. Poer pointed out that the 1956 annual session will be called the 106th Annual Session, while in reality it is only the 101st or perhaps the 102nd annual session of the Association. On motion duly made and seconded, it was recommended that this problem be referred to Council at the December meeting with the exact figure pertaining to the number of times the Association has had an Annual Session from its inception.

Chairman Allen called for unfinished business, and there being none, called for new business. Mr. Krueger presented a letter from Lester M. Petrie, Director, Preventable Disease Services of the State Department of Health, approved by Mr. M. D. Collins, Director, Georgia Department of Education and T. F. Sellers, Director, Georgia Department of Public Health. Dr. Petrie's letter concerned a recommendation made by the Joint Committee on Health and Education at their conference on leadership in school health held in

Athens, Georgia, last year. The recommendation asked for the formation of special committees to determine a battery of suitable health-screening tests which could be established as a periodic health appraisal for all personnel employed in the school system of Georgia. The letter further asks that the Medical Association of Georgia appoint an advisory committee of medical members qualified to specify the recommended tests. This letter, on motion duly made and seconded and approved, was referred to the Public Health Committee requesting that the committee recommend to the Council subsequent action concerning the requests contained in the letter.

Chairman Allen then called on J. W. Chambers for a report of the recent American Medical Association meeting concerning social security legislation in the Congress of the United States. Dr. Chambers presented a report for information of the Executive Committee of Council.

There being no further business, the meeting was adjourned at 6:25 p.m.

New Members of the M. A. G.

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Henry Berner Jones, Jr.	Gray	Active	Bibb
Larry A. Schwartz	2308 Ingleside, Macon	Active	Bibb
George W. Statham	341 W. Ponce de Leon Ave., Decatur	Active	DeKalb
Mark W. Fowler	500-A N. Slappey Dr., Albany	Active	Dougherty
Lonnie Richard Lanier, Jr.	1009 N. Monroe St., Albany	Associate	Dougherty
Clyde A. Burgamy	1167 University Pl., Augusta	Active	Richmond
James D. Grant	842 Greene St., Augusta	Active	Richmond
E. C. Jungck	1467 Harper St., Augusta	Active	Richmond
Stuart H. Prather, Jr.	842 Greene St., Augusta	Active	Richmond
Owen K. Youles, Jr.	1306 N. Patterson St., Valdosta	Active	South Ga.
W. E. Harden	Waycross	Active	Ware
Cecil F. Jacobs	922 E. Bay, Jesup	Active	Wayne
Edward Francis Kiszka	Emory University Hosp., Emory U.	Associate	Fulton
William N. Morrison	VA Hospital, Atlanta 19	Associate	Fulton
Garland Day Perdue, Jr.	Emory University Hosp., Emory U.	Associate	Fulton
Paul Franklin Tumlin	Georgia Baptist Hospital, Atlanta	Associate	Fulton

Plan Now to Attend
The 106th Annual Session
of the Medical Association of Georgia
May 13-16, 1956 — Atlanta Biltmore Hotel

ANNOUNCEMENTS

Sectional Meetings of the American College of Surgeons—Six sectional meetings to be held in cities throughout the U. S. and Canada during 1956 are as follows: Jacksonville, Fla., January 16-18; Philadelphia, Pa., Feb. 13-16; Milwaukee, Wis., Feb. 27-29; Colorado Springs, Colo., Mar. 5-7; Little Rock, Ark., Mar. 12-13; and Edmonton, Alta., April 23-25. Panels, symposia, papers, and medical motion pictures of greatest value to doctors practicing in the area are presented. For information write to Dr. H. Prather Saunders, Associate Director, American College of Surgeons, 40 East Erie St., Chicago 11, Ill.

Mediclinics of Minnesota Eight Day Course—Fort Lauderdale, Fla., March 5-14, 1956. Course will consist of 32 hours of instruction made up of lectures and panel discussions on subjects having an everyday application in the general practice of medicine. It is approved by the A. A. G. P. for credit for postgraduate study. Advance reservations must be filed by November 15, 1955. Tuition fee will be \$50.00 payable in advance. For reservations address Mediclinics of Minnesota, 516 Medical Arts Bldg., Minneapolis 2, Minn.

First International Congress of Human Genetics—August 1-6, 1956, Copenhagen, Denmark. Congress planned to cover all genetic aspects of normal and pathological characteristics in man. Provisional program and information sent on request of the Secretariate of the First International Congress of Human Genetics, The University Institute for Human Genetics, 14 Tagensvej, Copenhagen, N., Denmark.

16th Annual Congress on Industrial Health—January 23-24, 1956, Sheraton-Cadillac Hotel, Detroit, Mich. Principal speakers are Dr. Elmer Hess, President of the A.M.A., and Mr. Benson Ford, Vice-President of the Ford Motor Company. Topics to be discussed are "Occupational Medicine in Industrial Relations," "Medicine's Responsibilities in the Automotive Age," and "Absence from Work due to Nonoccupational Illness and Injury." For further information write to the Council on Industrial Health, A.M.A., 535 North Dearborn Street, Chicago 10, Ill.

International College of Surgeons Examinations for Fellows—Four oral and four written exams will be conducted in 1956. Oral conferences will be held on January 23, April 16, August 6, and October 22. Written examinations will be given on January 30-31, April 23-24, July 23-24, and October 29-30. These will be at the Cook County Hospital and Cook County Graduate School of Medicine, Chicago. The next convocation of the I.C.S. will be held in connection with the 21st annual congress in Chicago, September 9-13, 1956. For further information write to the Secretariat of the United States Section, International College of Surgeons, 1516 North Lake Shore Drive, Chicago 10, Ill.

Southeastern Regional Meeting of the International College of Surgeons—April 30-May 1, 1956, Read House, Chattanooga, Tenn.

Mississippi Valley Medical Society Essay Contest—Papers on any subject of general medical or surgical interest including medical economics and education may

be submitted, providing the paper is unpublished and is of interest and applicable value to general practitioners of medicine. Manuscripts, not exceeding 5000 words, must be submitted in five copies in manuscript style. Winning essay will receive a cash prize of \$100.00, a gold medal, and a certificate. Essays must be in the office of the Secretary of the M.V.M.S., Dr. Harold Swanberg, 209-224 W.C.U. Building, Quincy, Ill., not later than May 1, 1956.

Georgia Society of Ophthalmology and Otolaryngology, Annual Spring Meeting—March 9 and 10, 1956, General Oglethorpe Hotel, Savannah, Ga. The speakers on ear, nose, and throat subjects will be Dr. Chevalier L. Jackson, Philadelphia; Dr. Peter N. Pastore, Richmond; and Dr. Harry Rosenwasser, New York. Speakers on subjects pertaining to the eye will be Dr. F. Bruce Fralick, Ann Arbor; Dr. Frank D. Costenbader, Washington; and Dr. Irving H. Leopold, Philadelphia.

Symposium on Tuberculosis and Other Pulmonary Diseases in Childhood—March 12-16, 1956 (second session, first session is already filled) and June 4-8, 1956 (third session). The symposium is a full-time course of five days duration given under the direction of Dr. Edith M. Lincoln and Dr. Margaret M. H. Smith. It includes seminars and lectures on tuberculosis, pneumonia, and chronic chest diseases in childhood. For further information write to Office of the Dean, Post-Graduate Medical School, 550 First Avenue, New York 16, N. Y.

DEATHS

JULIUS C. BURCH, Atlanta, died on October 23, 1955, at the age of 65. Dr. Burch was stricken while visiting relatives and inspecting farm interests in Dublin.

A native of Laurens County, Dr. Burch was the son of the late D. W. and Sara E. Burch. He was a member of the Fulton County Medical Society, The American College of Chest Physicians, B.P.O.E. Lodge No. 78, and the Atlanta Rotary Club. He was also Mason and a Shriner. Dr. Burch was a member of the staff of the Fulton County Health Department.

Surviving are his wife; brothers, Mr. Clarence L. Burch of Dublin, Mr. Hamilton Burch of Valdosta, and Mr. Alex A. Burch of Macon; and a sister, Mrs. O. H. Duggan of Douglas.

Funeral services were held on October 24th in Dublin with burial in Northview Cemetery, Dublin.

HENRY TERRELL HARRISS, Washington, died on October 19, 1955, after a long illness. He was 81 years old.

A native of Augusta, Dr. Harriss had lived and practiced medicine in Washington for the past 30 years. During World War I Dr. Harriss did plastic surgery at the U. S. Army Hospital at Fort McHenry, Md., and during World War II he worked at Walter Reed Hospital. He received letters of commendation from both President Woodrow Wilson and President Franklin D. Roosevelt.

Dr. Harriss was a member of the Wilkes County Medical Society. He was a Woodman of the World, a member of the Washington Kiwanis, and a Mason.

Surviving are his wife, the former Miss Sonsi Helen Simmons, and a sister, Mrs. Ernst Fielding Arnold, Mount Airy, N. C.

(Deaths)

HOLLIS F. HOPE, SR., Atlanta, died November 2, 1955, at his home after suffering a heart attack. Dr. Hope was 64 years of age at the time of his death.

A graduate of the old Atlanta Medical College, now Emory, Dr. Hope engaged in private practice until he joined the Fulton County Health Department about 30 years ago. He was a member of the Fulton County Medical Society and the Second Ponce de Leon Baptist Church.

Dr. Hope was born in Atlanta, the son of the late Dr. and Mrs. R. L. Hope. Surviving are his wife, the former Mary Gray; a daughter, Mrs. M. K. O'Toole of New York; a son Mr. Hollis F. Hope, Jr., Atlanta, and four grandchildren.

FREDERIC COOPER WHELCHER, Rome, died on October 23, 1955, at his home in Rome. He was 64 years of age at the time of his death.

Born in Lula, Ga., Dr. Whelcher was educated at the University of Georgia, Emory University School of Medicine, and the University of Vermont Medical School. He practiced in Comer before becoming associated with the Georgia State Health Department, serving for a number of years at Alto Sanitarium. At the time of his death, Dr. Whelcher was assistant superintendent in charge of the X-ray department at Battey State Hospital. He was a member of the Floyd County Medical Society, the Sigma Nu Fraternity, and the Georgia Trudeau Society.

Immediate survivors are his wife, the former Miss Elise Davison of Comer; a daughter, Mrs. John Elchak; and a granddaughter.

Funeral services were held on October 25, 1955, at the graveside in Comer, Ga.

SOCIETIES

The THIRD DISTRICT MEDICAL SOCIETY held its Fall meeting in Americus on November 10, 1955. Bon M. Durham, Americus, welcomed the doctors and M. L. Malloy, Vienna, responded. The following physicians participated in the scientific session: J. D. Martin, Emory University, "Differential Diagnosis of Obstructive Jaundice"; Harry H. Brill, Columbus, "Hepatitis"; Darius Flinchum, Atlanta, "Hand Injury"; M. F. Arnold, Hawkinsville, "Two Cases of Anencephaly"; and William L. Caton, Emory University, "Gynecologic Lesions." J. L. Gallemore, Perry, was installed as president of the society, and the following officers were elected to serve with him in 1956: O. T. Gower, Cordele, vice-president; T. S. Gatewood, Americus, secretary; W. G. Elliott, Cuthbert, counselor, and Luther Wolff, Columbus, vice-counselor. H. Dawson Allen, Jr., Milledgeville, was a special guest at the meeting. Social hour and dinner followed the meeting at the Americus Country Club.

The FIFTH DISTRICT MEDICAL SOCIETY held its annual meeting on November 3, 1955, at the Academy of Medicine, Atlanta. Approximately 300 people were present to hear the guest speaker, Israel Steinberg of New York. New officers elected were Chester Morse, Decatur, president; John Slade, Atlanta, vice president; J. G. McDaniel, Atlanta, counselor; and Charles S. Jones, Atlanta, vice-counselor. J. S. Hilsman, Atlanta, continues as secretary-treasurer. The society passed a resolution criticizing Governor Marvin Griffin's method

of appointing members of the State Board of Health. (In several districts, Gov. Griffin has ignored the list of names submitted by the Council of the Medical Association of Georgia and has not requested additional names from the Council.) Dr. Hilsman announced that plans are under way for the society to bring another distinguished speaker to Atlanta next April.

BIBB COUNTY MEDICAL SOCIETY held its regular monthly meeting on October 4th at Pinebrook Inn; there were 59 members present to hear a panel discussion on the "Rh" problem by Charles Rumble, William Shirley, Lon King, Jr., all of Macon, and Miss Agnes Rowney (Chief Laboratory Technician at the Macon Hospital). Dr. Orr showed a film which he made at the Macon Hospital demonstrating replacement transfusion. The November meeting of the Bibb County Medical Society was held on November 8th at Pinebrook Inn. Refreshments were served at 6:30 with dinner at 7:30. Guest speaker for the meeting was William McCord, Charleston, S. C., who spoke on the subject of electrolytes. Dr. McCord holds the Ph.D. degree in addition to the M.D. degree and is professor of biochemistry at the Medical College of South Carolina.

DOUGHERTY COUNTY MEDICAL SOCIETY has adopted an Emergency Medical Service which will enable local citizens to obtain the services of a physician in time of emergency. The plan is for the person in need of help, who cannot locate his own physician, to call the Phoebe Putney Memorial Hospital Emergency Room. The nurse there will see to it that a physician is on hand when the patient arrives at the hospital; she will also make arrangements for an ambulance. The society has also moved in another direction to improve public relations—the Press Relations Committee of the society had a dinner party for representatives of the press, radio, and television in Albany.

The GEORGIA MEDICAL SOCIETY met on November 8, 1955, at 612 Drayton Street. Murray M. Copeland of Georgetown University Medical Center in Washington, D. C., addressed the members on "Diagnosis and Treatment of Premalignant Lesion of the Breast." A graduate of Johns Hopkins Medical School, the visiting surgeon completed graduate work at the Memorial Hospital in New York. He is a native of McDonough, Ga. Ruskin King, Savannah, was elected president of the society for 1956.

MUSCOGEE COUNTY MEDICAL SOCIETY celebrated its golden anniversary at a banquet on October 26, 1955. Highlight of the evening was the presentation of honor scrolls to four senior members of the society: William Lawrence Cooke, in absentia, George Stewart Murray, James Clements Wooldridge, and James Rufus Youmans. They were introduced by Frank Schley. James Elkins, president of the society, presided over the social hour and dinner, and special guests for the occasion were Dr. and Mrs. H. Dawson Allen, Jr., of Milledgeville, and Dr. and Mrs. J. C. Patterson, of Cuthbert.

The RICHMOND COUNTY MEDICAL SOCIETY met in Augusta on October 25, 1955. A discussion of "Precocious Puberty of Both Sexes" was held by William E. Barfield and E. C. Jungck, both members of the faculty of the Medical College of Georgia.

The WARE COUNTY MEDICAL SOCIETY met recently

to hear a talk on the range of utility of radioactive isotopes by Mr. James Searls, representative of the Abbott Pharmaceutical Company for the U. S. and Canada. Hosts for the meeting at the Golf Club of Waycross were B. F. Minchew and Sam Victor, Waycross.

The WHITFIELD-MURRAY COUNTY MEDICAL SOCIETY held an open meeting to discuss alcoholism as a community problem on November 16, 1955. Invitations were sent to civic organizations, clubs, juvenile authorities, policemen, sheriff's officers, and others in Dalton who work with the alcoholic problem to hear an address by Mr. Paul Fraser, Atlanta, a member of the Georgia Commission on Alcoholism.

PERSONALS

First District

THOMAS W. COLLIER, Brunswick, has been released from the hospital after suffering a mild coronary attack. Dr. Collier is at home recuperating and plans to be away from his office for the next few months.

ERNEST G. EDWARDS, JR., Savannah, has been elected to membership in the American Academy of Orthopedic Surgeons.

The new clinical laboratory of the Memorial Hospital in Savannah will be under the direction of LEE HOWARD, JR., Savannah, pathologist in charge of the department. With the new lab, Memorial Hospital is the only hospital in Savannah which is equipped to do its own lab work in its own building.

After practicing 53 years of practice and delivering 4200 babies, JESSE M. MCELVEEN, Brooklet, has retired. In 1902 Dr. McElveen began the practice of medicine at Denmark, Ga., and in the spring of 1905 he went to Brooklet. He and Mrs. McElveen, the former Miss Bessie Brown, will celebrate their 50th wedding anniversary next April.

At a recent meeting of the Board of Directors of the First District Chapter, Georgia Heart Association, FENWICK T. NICHOLS, JR., Savannah, reported for the Heart Clinic that a total of 92 new patients came to the clinic during the past quarter, 644 patients were seen by Heart Clinic doctors, and 1756 visits by patients were made to the clinic during the quarter; 344 doctor hours were spent in the clinic. Dr. Nichols was made chairman of the rheumatic fever committee of the association at this meeting. Other appointments made at the meeting for the coming year are as follows: JOHN L. ELLIOTT, Savannah, membership committee chairman; C. J. WILLIAMS, Savannah, professional and clinic committee chairman; and ELLISON R. COOK, III, Savannah, was named to the executive committee.

Second District

T. GRAY FOUNTAIN, Albany, has been made a diplomate of the American Board of Surgery. Dr. Fountain is a native of Butler and a graduate of Emory University and Emory University School of Medicine. He was chief surgical resident at Emory University Hospital during 1953 and 1954. He is associated with O. GREY RAWLS, who is also a diplomate of the American Board of Surgery, in Albany. Both physicians have been in Albany since July 1, 1954.

H. B. JENKINS, Donalsonville, spoke to the members of the Blakely Lions Club recently. Dr. Jenkins is in the U. S. Army Reserve Corps and had just recently returned from a conference in Washington, D. C., concerning atomic energy and its uses. In his talk to the Lions he emphasized the fact that "friendship and the good neighbor policy are our best defense against atomic weapons which, if put to the test, would cause destruction such as the world has never known before."

OSCAR M. MIMS, Thomasville, discussed rheumatic fever and its relation to heart ailments for the Colquitt County Home Demonstration Clubs. The meeting in Moultrie, to which the public was invited, was part of an education campaign to acquaint the public with facts about heart ailments that result from rheumatic fever.

FREDERICK E. MURPHY, JR., Thomasville, recently addressed a meeting of the Valdosta Rotary Club; he told the members assembled what is being done in Georgia for the relief of crippled children. He said the program, which is conducted jointly by the federal and state governments, involves the expenditure of approximately half a million dollars a year and treatment of from 12,000 to 15,000 children.

Third District

MAURICE F. ARNOLD Hawkinsville, was elected president-elect of the Georgia Academy of General Practice at the organization's annual meeting held in Augusta in October. Dr. Arnold was vice-president last year and previously served as secretary-treasurer for three years.

W. G. ELLIOTT, Cuthbert, was installed as president of the Georgia Academy of General Practice at the recent annual meeting held in Augusta.

Two physicians from the Third District have been made fellows of the American College of Surgeons. They are LOUIS A. HAZOURI, Camp Gordon, and ROBERT H. VAUGHAN, Columbus.

JOHN H. ROBINSON, Americus, has been elected to the Board of Aldermen in Americus. He received 735 more votes than the incumbent who was defeated.

At a recent meeting of the Cemochechobee Club in Coleman, Mr. Joe M. Ray, Cuthbert attorney, entertained the members of the club with a talk on "Living in Small Towns." He called particular attention to the services rendered by outstanding citizens and asked that Coleman and Randolph County citizens pay tribute to the late T. F. Harper, Coleman, and FLOY S. ROGERS, Coleman, for their splendid service rendered to the Coleman community and to the county at large. Dr. Harper would have practiced in the county for 50 years this year had he lived, and Dr. Rogers is now serving his 58th year as a physician in his community.

HAYWOOD TURNER and JOHN K. DAVIDSON, Columbus, were guest speakers at a recent luncheon meeting of the Rotary Club. They discussed hypertension, coronary thrombosis, and obesity.

JOHN M. WILSON, Columbus, announces his return from the Armed Services and the re-opening of his office for the practice of medicine and surgery, 208 Martin Building, Columbus.

Fourth District

THOMAS REEVE, Carrollton, has been elected chief of staff of Turner Memorial Hospital for the coming

year. W. STEVE WORTHY was named vice-chief of staff and chief of OB and Gyn, and FRANCIS M. PARKS, secretary-treasurer. Other posts on the staff will be taken by the following: E. V. PATRICK, chief of surgeons; E. C. BASS, chief of medicine; D. S. REESE, chief of EENT; and PHIL C. ASTIN, Jr., chief of scientific service.

Fifth District

Fourteen Atlanta doctors gave talks at the Southern Medical Association meeting held recently in Houston, Texas. Three, each chairman of a section, presented the chairman's address to their groups. They are LESTER RUMBLE, JR., anesthesiology; JOE M. BOSWORTH, industrial medicine; and HARRIET E. GILLETTE, physical medicine and rehabilitation. The following presented papers: FREDERICK A. CARPENTER, WILLIAM H. GALVIN, ARTHUR M. PRUCE, EXUM B. WALKER, TRUETT V. BENNETT, J. JACK STOKES, WOOD LOVELL, RICHARD E. KING, JACK B. NORRIS, WILLIAM R. CHAMBERS, and WALTER H. CARGILL. OSLER ABBOTT, WILLIAM E. VAN FLEIT, WILLIAM A. HOPKINS, WILLIAM R. CHAMBERS and JACK C. NORRIS presented exhibits.

L. MINOR BLACKFORD, Atlanta, is chairman for the state of Georgia for the collection of contributions for a memorial fund honoring the late T. Duckett Jones, internationally famous authority on rheumatic fever and rheumatic heart disease. The fund will support outstanding young scientists seeking investigative careers in rheumatic fever and related fields.

WILLIAM S. COMPTON, Atlanta, recently spoke to the Doraville Woman's Club on his trip to the North Pole.

Marvin L. Davis, Atlanta, has opened offices in the Buckhead Professional Building on Maple Drive for the practice of pediatrics. A native of Atlanta, Dr. Davis attended Mercer University and was graduated from the Medical College of Georgia. He comes to Atlanta from Los Angeles, Cal., where he has been a practicing pediatrician for the last few years.

M. BEDFORD DAVIS, JR., and EDWARD K. RUSSELL, Atlanta, presented a paper on "The Physiopathology of Smoking" at a recent meeting of Atlanta Clinical Society. Hosts for the meeting were SAMUEL S. AMBROSE, A. V. GUDE, and J. FRANK HARRIS.

DANIEL C. ELKIN, former chairman of the department of surgery of Emory University School of Medicine, has been named president-elect of the American College of Surgeons. Dr. Elkin is the first Georgian to be so honored.

Dr. and Mrs. MURDOCK EQUEN, Atlanta, took a Thanksgiving cruise to the Hawaiian Island. They flew to San Francisco on November 16 and from there took a boat to Honolulu. While there they stayed at the Royal Hawaiian Hotel. They returned to Atlanta December 4th.

EUGENE B. FERRIS, Atlanta, was elected vice-president of the American Heart Association at the annual meeting of the assembly of the association. Four other Georgians were named to the American Heart Association's Board of Directors. They are R. BRUCE LOGUE, Atlanta; CARTER SMITH, Atlanta; WILLIAM F. HAMILTON, Augusta; and ARTHUR J. MERRILL, Atlanta.

HARRIET E. GILLETTE, Atlanta, has been named the 1955 Medical Woman of the Year by the Atlanta Branch of the American Medical Women's Association. "Dr. Gillette was named for this honor for her insight and farsighted approach to the needs of the cerebral palsied and the aged," VERNELLE FOX, branch president, said. "Her medical clinic instruction and her efforts to improve rehabilitation throughout Georgia are greatly aiding these two groups." Dr. Gillette was guest editor of the October issue of the *Journal of the American Medical Women's Association*. Several Atlanta physicians contributed articles to this issue: DOROTHY BRINSFIELD, HELEN W. BELLHOUSE, MARGUERITE L. CANDLER, and Dr. Gillette.

The Georgia Pediatric Society met in October with its president, JAMES P. HANNER, Atlanta, presiding. Other officers are STEPHEN REDD, Atlanta, vice-president; and C. DIXON FOWLER, Atlanta, secretary-treasurer.

A. H. LETTON, Atlanta, and Mrs. Letton attended the meeting of the Alabama Section of the International College of Surgeons, which was held in Mobile. They visited Dr. and Mrs. Mahorner in New Orleans while they were away.

J. WILLIS HURST, Emory University, has been promoted to Commander in the United States Naval Reserve.

PETER HYDRICK, College Park, was moderator of a forum on the uses and benefits of the Salk polio vaccine at the Seventh Annual Session of the Georgia Academy of General Practice held in Augusta in October. Other members of the panel were JOHN H. VENABLE and JOSEPH PATTERSON, all of Atlanta.

R. BRUCE LOGUE, Emory University, has recently been made a member of the Examining Board of the Subspecialty Board in Cardiology. On November 11th, Dr. Logue gave a talk on "The Treatment of Rheumatic Fever" before the meeting of the American College of Cardiology at Memphis, Tenn. On November 16th, he read a paper on "Errors in the Diagnosis and Treatment of Heart Disease" before the Seventh (N.C.) District Medical Society meeting in conjunction with the North Carolina Heart Association at Wadesboro, N. C.

HAROLD P. McDONALD, Atlanta, recently delivered two addresses at the second annual meeting of the Western Sector of the Mexican Urological Association in Leon, Mexico. One was "Transthoracic Nephrectomy," the other, "Transurethral Prostatectomy."

LAMAR B. PEACOCK, Atlanta, has accepted the appointment as director of the medical branch of Atlanta Metropolitan Area's Civil Defense organization. A staff of volunteer nurses and doctors will assist him in preparing the community to meet medical needs in the event of an enemy attack of natural disaster.

ALFRED A. WEINSTEIN, Atlanta, spoke to the Atlanta Registered Nurses when they met for the Spalding Institute for Registered Nurses. The institute is a back-to-school movement to keep local nurses abreast of medical advances and provide them with incentive to improve their care of patients. Dr. Weinstein spoke on "The Art and Science of Rest and Relaxation."

Sixth District

A new medical office building has recently been completed at 724 Hemlock Street on the corner of First Street in Macon and is now occupied by the following physicians; HAROLD C. ATKINSON, B. W. FORESTER, H. M. OLNICK, CHARLES RICHARDSON, JR., J. P. WOODHALL, CALDER B. CLAY, JR., and WALTER D. BARNES, JR.

HOLLOWAY BUSH, Macon, and his partner won the City Men's Championship Bridge Tournament recently.

Two Macon physicians were among the 950 surgeons inducted recently as fellows of the American College of Surgeons at the annual Clinical Congress in Chicago. They are CALDER B. CLAY, JR., and W. DEVEREAUX JARRATT, JR.

BRASWELL COLLINS, DUNCAN WALKER, JR., and Dr. and Mrs. WILLIAM BARTON, all of Macon, attended the Fall meeting of the National Academy of Ophthalmology and Otolaryngology.

LOVICK E. DICKEY, JR., Macon, announces the opening of his office at 724 Hemlock Street in Macon for the practice of orthopedic surgery.

O. R. THOMPSON, Macon, President of the Georgia State Obstetrical and Gynecological Society, presided at the interim meeting of the society held in Macon. Some 50 obstetricians, gynecologists, and general practitioners attended the meeting at which Luke Gillespie, of Harvard University, and L. L. Hester, of the University of South Carolina, were guest speakers. They also participated in a panel discussion with GEORGE WILLIAMS, Atlanta, and A. J. KELLY, Savannah; Dr. Thompson moderated the panel.

Seventh District

S. U. BRALY, Dallas, announced the association with him in the practice of medicine of Joseph M. Scott, of Memphis, Tenn. Their offices will be in the Paulding County Hospital.

ALFRED O. COLQUITT, Marietta, and WALTER G. HACKETT, Rome, have been made fellows of the American College of Surgeons.

LEWIS R. LANG, Calhoun, has purchased a house at 323 South Wall Street and will move his office there before the first of the year; his present office is on Court Street, Calhoun.

EARL MCGHEE, Dalton, has been elected president of the Whitfield County Citizens Council.

Eighth District

ARTHUR M. KNIGHT, JR., J. T. FERRELL, NEAL F. YEOMANS, WILBUR L. FLESCHE, W. B. BATES, and WILLIAM E. HARDEN, all of Waycross, composed the panel for a recent Ware County Medical Forum broadcast over station WAYX. The subject of the discussion was "Cancer"; the forum was sponsored by the Ware County Medical Society. FLOYD E. DAVIS, Waycross, is forum chairman for the society.

THOMAS L. PARKER, Douglas, has been made a fellow of the American College of Surgeons.

SAM VICTOR, Waycross, served as moderator in another medical forum sponsored by the Ware County Medical Society, of which he is president. The subject

for discussion was "Surgery Today," and the panel included KATHERINE HENDRY, LOVICK PIERCE, LEO SMITH, ANSLEY SEAMAN, and W. C. CALHOUN.

Ninth District

RAFE BANKS, JR., Gainesville, was one of the speakers at the recent meeting of the Georgia Academy of General Practice in Augusta. Dr. Banks presented a paper on "Office Urology in General Practice."

C. J. ROPER, Jasper, had the unfortunate experience of making the front page of the Gainesville newspaper for having his safe stolen from his home and two people in his house shot at by the desperadoes who absconded with the safe. Luckily neither the maid nor Dr. Roper's brother was wounded. The three culprits were later apprehended, but the whereabouts of the missing safe were unknown at the latest report.

Tenth District

THOMAS E. BAILEY, Augusta, spoke at the November meeting of the Mount Saint Joseph's Mothers' Club of Augusta on "Physical Health of the Child and Accident Prevention in the Home."

CHARLES I. BRYANS, JR., and JOHN T. PERSALL, Augusta, have been made fellows of the American College of Surgeons. Dr. Bryans, a native Augustan, is a graduate of the University of Georgia and the Medical College of Georgia. He served during World War II with the Army Medical Corps and practiced in Baxley for three years after his release from the service. He returned to Augusta for further training in 1948, was recalled to active duty with the Army in 1950 to serve until 1953, and is now in the private practice of obstetrics and gynecology in Augusta. Dr. Persall is a native of Cordele, a graduate of the University of Georgia and the Emory University School of Medicine. From 1934 until 1940 he served in the Army Medical Corps. He is now assistant professor of obstetrics and gynecology at the Medical College of Georgia.

John R. Fair has been appointed assistant professor of surgery and chief of ophthalmology at the Medical College of Georgia. Dr. Fair is a graduate of Loyola University, Chicago, and the Loyola University College of Medicine. He interned at Jackson Memorial Hospital in Miami, Fla., and served three years residency in ophthalmology in Army hospitals after which he was appointed assistant director of the Ocular Research Unit, Walter Reed Army Medical Center. In 1954, Dr. Fair served as chief of the eye section of the Army's 98th General Hospital in Germany. He resigned from this post with the rank of lieutenant colonel. He is a diplomate of the American Board of Ophthalmology, a fellow of the American College of Surgeons, and a member of the Association for Research in Ophthalmology and the A.M.A.

G. LOMBARD KELLY, Augusta, has recently addressed the Academies of General Practice of Louisiana, in Shreveport, New York in New York City, and Maryland in Baltimore, on "Problems of Libido and Potentia Encountered by the General Practitioner."

RUFUS PAYNE, Augusta, was a guest speaker at the recent meeting in Augusta of the Evangelical Ministers Association. Lester Rumble, D.D., father of LESTER RUMBLE, JR., Atlanta, was chairman of the program committee for the meeting.

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